

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15(4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03596

CERTIFICATE OF DEATH

03590

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR		
BERNARD					PARKER	MARCH 8, 1969			6:00 AM		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
MALE		NEGRO		MAY 13, 1913			55 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.	
MARYLAND		USA					BALTIMORE				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
FORT HOWARD			HOSPITAL VETERANS ADMINISTRATION			LABORER					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
MARYLAND			BALTIMORE		BALTIMORE				1126 ARYGLE AVENUE		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
SOLOMAN					PARKER	UNK.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address					
YES			WW II			213 16 5056 CLINICAL RECORDS, VA HOSPITAL, FT HOWARD, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>427.0 CONGESTIVE CARDIAC FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) <u>PULMONARY EMPHYSEMA</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>3/1/69</u> , 19 <u>69</u> , to <u>3/8/69</u> , 19 <u>69</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>3/8/69</u> , 19 <u>69</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> view the body after death.											
22b. SIGNATURE <u>Madhav D Barhanpukur</u>						22c. DATE SIGNED 3 8 69					
22d. PHYSICIAN'S NAME (Type) MADHAV D. BARHANPUKAR, M.D.						22e. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 3-13-69		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL			23d. LOCATION (City or Town) (County) (State) BALTIMORE MD.			
24. FUNERAL DIRECTOR MORTON & DYETT FUNERAL HOME 1701 LAURENS ST.						25a. REC'D BY REGISTRAR MAR 10 1969			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

03236

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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
JAMES BERTEN PARKER						March 20 1969		1:15 A.M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
Male		White		1/23/92		77 YRS.		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Massachusetts		U.S.A.				BALTIMORE Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during last of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
FORT HOWARD			Veterans Administration Hospital							
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND					BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		206 W. MONUMENT STREET	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT					
YES			WW-1		Address					
			215 05 6676		CLINICAL RCDS, VA HOSPITAL, FORT HOWARD MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:									Days	
IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u>										
DUE TO, OR AS A CONSEQUENCE OF (b) <u>OBSTRUCTIVE EMPHYSEMA</u>										
DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natally medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (X) (this hospital) attended the deceased from <u>Mar. 19</u> , 19 <u>69</u> , to <u>Mar 20</u> , 19 <u>69</u> , that (X) (we) last saw the deceased alive on <u>Mar. 20</u> , 19 <u>69</u> , and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (do not) view the body after death.										
22b. SIGNATURE					DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED	
<u>J. D. Talbert M.D.</u>									3/20/69	
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS					
J. D. TALBERT, M.D.					VAH F RT HOWARD MD.					
23a. BURIAL, CREMATION, (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		3/24/69		Baltimore National		Baltimore, Maryland				
24. FUNERAL DIRECTOR					25. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
<u>ZANNINO FUNERAL HOME</u>					DATE		<u>Charles Judge</u>			
					257 S. Conkling Balto, Md.		MAR 26 1969			

03252

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ADMINISTRATIVE

UNIT 1000

UNIT 1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03598

CERTIFICATE OF DEATH

03592

1. DECEASED-NAME (Type or print) Etta Pfeffer Penn			2a. DATE OF DEATH Month 3 Day 12 Year 1969			2b. HOUR 7:30pm	
3. SEX female		4. RACE white		5. DATE OF BIRTH February 26, 1925		6. AGE (In years last birthday) 44 YRS.	
7a. BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore County Md.	
10. CITY OR TOWN OF DEATH Home, Pikesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Chapel Hill Nursing Home, Pikesville		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife-secretary		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland 3100 Donna Road		13b. COUNTY Baltimore		13c. CITY OR TOWN YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 3100 Donna Rd	
14. FATHER'S NAME First Mat Middle Pfeffer Last Same		15. MOTHER'S MAIDEN NAME First Same Middle Pfeffer Last Same		16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)		17. INFORMANT Mitchell Penn Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ca of sigmoid with generalized melostasis DUE TO, OR AS A CONSEQUENCE OF (b) melostasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on 3/12 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Rafael L. Aybar DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 3/12/69			
22d. PHYSICIAN'S NAME (Type) RAFAEL L. AYBAR				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 3/14/1969		23c. NAME OF CEMETERY OR CREMATORY Moses Montefiore		23d. LOCATION (City or Town) (County) (State) Baltimore	
24. FUNERAL DIRECTOR Sylvan S. Lewis & Son, INC		ADDRESS 9610 Reisterstown Rd		25a. REGD. BY REGISTRAR MAR 17 1969		25b. REGISTRAR'S SIGNATURE Juanita Judge	

63252

STATE OF NEW YORK

IN SENATE,	
January 1, 1901.	
REPORT	
OF THE	
COMMISSIONERS OF THE LAND OFFICE	
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE	
MAY 1, 1899.	
ALBANY:	
J. B. LIPPINCOTT & CO., PRINTERS.	
1901.	

ALBANY: J. B. LIPPINCOTT & CO., PRINTERS. 1901.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03599

CERTIFICATE OF DEATH

03593

1. DECEASED NAME (Type or print) JAMES		First	Middle	Lost	2a. DATE OF DEATH March Month 9 Day 1969 Year		2b. HOUR 2:15 a		
3. SEX Male		4. RACE White		5. DATE OF BIRTH 9-9-1894		6. AGE (In years lost, birthday) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore			Md.
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph's Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Perry Hall		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Silver Spring Rd. 21128	
14. FATHER'S NAME Edward		First	Middle	Lost	15. MOTHER'S MAIDEN NAME Theresa		First	Middle	Lost Dohmeyer
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, none unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO.		17. INFORMANT Eugene Peters Silver Spring Rd Perry Hall					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4123 IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Edema DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (the hospital) attended the deceased from March 9 19 69 , to March 9 19 69 , that (I) (we) last saw the deceased alive on March 9 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Jaime Punzalan		DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 3-9-69			
22d. PHYSICIAN'S NAME (Type) Dr. Jaime Punzalan		22e. ADDRESS 7620 York Rd., Towson, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-12-1969		23c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cemetery		23d. LOCATION (City or Town) Fullerton		(County) Balto.	(State) Md
24. FUNERAL DIRECTOR Lassahn Funeral Home 7401 Belair Road 21236				ADDRESS		25a. REC'D BY REGISTRAR DATE PAR 11 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

1. The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that proper record-keeping is essential for the integrity of the financial system and for the ability to detect and prevent fraud.

2. The second part of the document describes the various methods used to collect and analyze data. It includes a detailed discussion of the statistical techniques employed to identify trends and patterns in the data. The analysis shows that there is a significant correlation between the variables studied, which supports the hypothesis that the system is functioning as intended.

3. The third part of the document presents the results of the study. It includes a series of tables and graphs that illustrate the findings. The data indicates that the system is generally stable, but there are some areas where further investigation is needed. Specifically, the results show that there is a slight increase in the number of errors over time, which may be due to changes in the system or to human factors.

4. The final part of the document provides recommendations for future research. It suggests that further studies should be conducted to explore the causes of the errors and to develop strategies to minimize them. It also recommends that the system be regularly monitored and updated to ensure its continued effectiveness.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03600

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03594

1. DECEASED-NAME (Type or Print) Anthony P. Petrecca Sr.		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 3 Day 25 Year 1969		2b. HOUR 7:40A
3. SEX Male	4. RACE Cau	5. DATE OF BIRTH June 29, 1923	6. AGE (In years last birthday) 45 YRS.	7. IF UNDER 1 YEAR MONTHS 0 DAYS 0
7a. BIRTHPLACE (State or foreign country) Balto., Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore
10. CITY OR TOWN OF DEATH Sparrows Point, MD.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Bethlehem Steel Dispensary		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Clerk
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD. COUNTY Baltimore		13b. CITY OR TOWN Baltimore	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET AND NUMBER 3301 Fleet St. 21224
14. FATHER'S NAME First Vincent Middle Petrecoa Last 		15. MOTHER'S MAIDEN NAME First Antoinette Middle Ficca Last 		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO. 215-16-9885		17. INFORMANT Eleanor M. Petrecca ADDRESS Balto., 3301 Fleet St. 24, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A-S-C*V Disease 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) 				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) O N				
19a. DATE OF OPERATION N		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? E		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH O		21b. TIME OF INJURY Month, Day, Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) O
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) E		21f. LOCATION Street or R.F.D. No. E City or Town County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE Melvin B. Davis		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED March 25, 1969
EXAMINER'S NAME (Type) 6800 Morningson Rd. Baltimore Md. 21222		ADDRESS (Street, city, town, or county) 		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3-28-69.	23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery		23d. LOCATION (City or Town) (County) (State) 7401 German Hill Rd., Ba. Co., Md.
24. FUNERAL DIRECTOR Charles S. Zeiler		25a. REC'D BY REGISTRAR MAR 28 1969		25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03601		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03595	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) First Middle Last SARAH KATHRYN PFAFFKO			2a. DATE OF DEATH 03 Month 11 Day 69 Year			2b. HOUR 11:15	
3. SEX FEMALE		4. RACE CAUC		5. DATE OF BIRTH 06-16-12		6. AGE (In years last birthday) 56 YRS.	
7a. BIRTHPLACE (State or foreign country) Penna.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE CO. Md.	
10. CITY OR TOWN OF DEATH TOWSON, MD.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Baltimore Med. Cent.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Secretary		12b. KIND OF BUSINESS OR INDUSTRY School	
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE Penna.		13b. COUNTY Franklin		13c. CITY OR TOWN Waynesboro		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER R. D. 4		14. FATHER'S NAME First Middle Last E. Reuben McClain		15. MOTHER'S MAIDEN NAME First Middle Last Sarah E. Fitz		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) no	
16b. SOCIAL SECURITY NO. 203-10-1862		17. INFORMANT Mr. Arthur G.W. Pfaffko Jr.		Address 18 E. North St. Waynesboro, Pa.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) OBSTRUCTIVE JAUNDICE DUE TO LIVER METASTASIS DUE TO, OR AS A CONSEQUENCE OF (c) CA OF BREAST APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE	
19a. DATE OF OPERATION NOV. 67		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 2-22, 1969, to 3-11, 1969, that (I) (we) last saw the deceased alive on 3-11, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE B.R. Choi M.D.		DEGREE M.D.		ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type) B.R. CHOI		22a. ADDRESS 6701 NORTH CHARLES STREET					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/14/1969		23c. NAME OF CEMETERY OR CREMATORY Calvary		23d. LOCATION (City or Town) (County) (State) Waynesboro #4, Franklin, Pa.	
24. FUNERAL DIRECTOR James G. Lane Waynesboro, Pa.				25a. RECEIVED BY REGISTRAR MAR 14 1969		25b. REGISTRAR'S SIGNATURE James G. Lane	

UNITED STATES OF AMERICA		DEPARTMENT OF THE ARMY	
OFFICE OF THE ADJUTANT GENERAL		HEADQUARTERS, 10000	
1. NAME (Last, First, Middle)		2. GRADE	
3. SERVICE NUMBER		4. DATE	
5. PLACE OF BIRTH		6. DATE OF BIRTH	
7. SOCIAL SECURITY NUMBER		8. MARITAL STATUS	
9. EDUCATION		10. OCCUPATION	
11. RELIGION		12. RACE	
13. HEIGHT		14. WEIGHT	
15. HAIR COLOR		16. EYE COLOR	
17. COMPLEXION		18. BLOOD TYPE	
19. SIGNATURE		20. DATE	
21. ADDRESS		22. CITY	
23. STATE		24. ZIP CODE	
25. PHONE NUMBER		26. FAX NUMBER	
27. E-MAIL ADDRESS		28. COMMENTS	

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03602

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03596

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR		
FRANCIS HART PHELPS, JR.						MARCH 28 1969			3:45 M		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
MALE		WHITE		6/19/16			52 YRS.		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.	
MARYLAND		U.S.A.					BALTIMORE				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
FORT HOWARD		VETERANS ADMINISTRATION HOSPITAL			TECHNICAL EDITOR			U.S. ARMY			
13a. USUAL RESIDENCE (Where deceased admission) STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER		13e. BOX 101 21057			
MARYLAND		BALTIMORE		GLENARM							
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
FRANK H. PHELPS						MARGARET BARNITZ					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, or unknown) (If yes, give year or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT			Address			
YES PL-28			215 15 04 57		Clinical Rcds, VA Hospital, Fort Howard, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1890 BRONCHOPNEUMONIA DUE TO, OR AS A CONSEQUENCE OF WIDESPREAD METASTATIC ADENOCARCINOMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) SURGICAL ABSENCE, RIGHT KIDNEY (ADENOCARCINOMA, REMOVED) (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Recent OLD	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CYSTOSTOMY											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 3, 19 69, to March 28 19 69, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 28 19 69 and that in <input checked="" type="checkbox"/> (my) <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.											
22b. SIGNATURE Nadhar D. Barharturker						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/28/69			
22d. PHYSICIAN'S NAME (Type) Dr. Nadhar D. Barharturker						22e. ADDRESS VA Hoapital, Fort Howard, Maryland					
23a. BURIAL, CREMATION, OTHER (Specify)		23b. DATE 3/31/1969		23c. NAME OF CEMETERY OR CREMATORY WOODLAWN CEMETERY			23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND				
24. FUNERAL DIRECTOR HENRY W. JENKINS, 4905 YORK RD BALTO MD						25a. REC'D BY REGISTRAR DATE 1 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

50380

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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2

1

03603

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03597

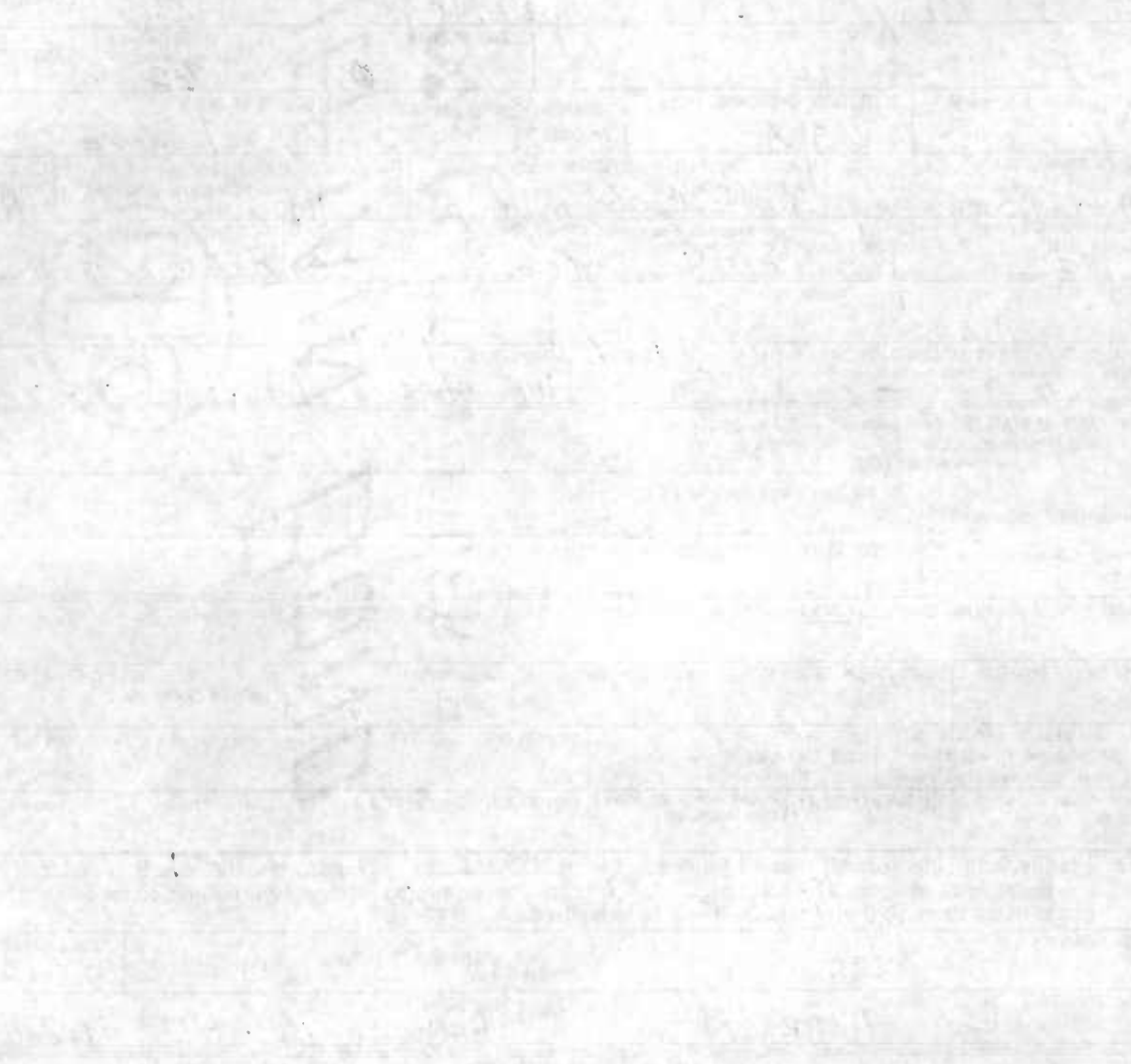
1. DECEASED-NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH			2b. HOUR		
Amy				C	Phillips	March 4 1969			11:25 AM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
F		W		1-6-07		62 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
W. VA.		U.S.A.				BALTIMORE Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
RANDALLSTOWN			BALTO. CO. GEN. HOSP			Housewife			Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Md.			CARROLL		Sykesville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Arthur Ave.		
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First	Middle	Lost
Mose						Emma					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT			Address			
NO			?		MR. Charles Phillips			Sykesville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stress Ulcer → Hemorrhage 485X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pneumonia, Rollo DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from March 1, 1969, to March 4, 1969, that (I) (we) lost the deceased alive on March 4, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			22c. DEGREE			22d. ADDRESS			22e. DATE SIGNED		
G. Wearjon						BALTO. CO. HOSPITAL RANDALLSTOWN, MD.			3/4/69		
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS			22f. DATE			22g. REGISTERAR'S SIGNATURE		
G. Wearjon			BALTO. CO. HOSPITAL RANDALLSTOWN, MD.			MAR 10 1969			Charles Judge		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial			3-6-69		Lak View Cemetery		Sykesville Md.				
24. FUNERAL DIRECTOR			25. REC'D BY REGISTRAR								
Harry W. Haight Sykesville, Md.			DATE MAR 10 1969								

1964

UNITED STATES DEPARTMENT OF AGRICULTURE

WATER RESOURCES DIVISION

05003



1964 05003

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03598		
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or Print) Dorothy			First E. Middle Phipps Last			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 3 Day 29 Year 1969			2b. HOUR 4:30 P.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH Sept. 22, 1925		6. AGE (In years last birthday) 43 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN 		
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore			
10. CITY OR TOWN OF DEATH Dundalk				11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 7589 Ives Lane				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) School teacher-Balto.			12b. KIND OF BUSINESS OR INDUSTRY City	
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE Maryland				13b. COUNTY 		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 332 Imla Street		
14. FATHER'S NAME First George Middle Last Markel Sr.				15. MOTHER'S MAIDEN NAME First Edna Middle M. Last Seibert								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16b. SOCIAL SECURITY NO. 220-18-3431		17. INFORMANT (Husband) Mr. Lee J. Phipps Sr.				ADDRESS 332 Imla St. Balto. Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain Tumor 2381 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 13 mos =		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) None												
19a. DATE OF OPERATION Feb + Aug. 68				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Brain Tumor				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 				21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M. 				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) None				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) None				21f. LOCATION-Street or R.F.D. No. City or Town County State 				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE Melvin B. Davis				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED 3/31/69				
EXAMINER'S NAME (Type) Melvin B. Davis				M.D. M. D.				ADDRESS (Street, city, town, or county) 6800 Morningson Rd. Dundalk, Md. 21222				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 4/2/69			23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.						ADDRESS 		25a. REC'D BY REGISTRAR APR 2 1969		25b. REGISTRAR'S SIGNATURE Charles Under		

13804

AMERICAN LABORATORY SERVICE OF DEATH

Name		Address	
Room		City	
State		Zip	
Telephone		Fax	
E-mail		Web	
Occupation		Education	
Marital Status		Religion	
Date of Birth		Date of Death	
Cause of Death		Manner of Death	
Medical History		Current Medications	
Family History		Social History	
Physical Examination		Laboratory Tests	
Immunization Status		Travel History	
Allergies		Other Medical Conditions	
Mental Health History		Substance Use History	
Autopsy Results		Toxicology Results	
Pathology Findings		Microbiology Results	
Radiology Findings		Genetics Results	
Histology Findings		Immunohistochemistry Results	
Molecular Biology Results		Other Special Studies	
Final Report		Signature of Pathologist	
Date of Report		Contact Information	

FOR STATE
HEALTH DEPT.

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03605

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03599

1. DECEASED-NAME (Type or Print) MYRTLE MARTIN PILSON						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year March 12 1969			2b. HOUR 6:22 PM			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH FEB. 18, 1918		6. AGE (In years last birthday) 51 YRS.		IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>		
7a. BIRTHPLACE (State or foreign country) PATRICK CO., VA.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH BALTO., Co.			
10. CITY OR TOWN OF DEATH TOWSON				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 705 OVERBROOK RD.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.				13b. COUNTY BALTO		13c. CITY OR TOWN TOWSON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 705 OVERBROOK RD.		
14. FATHER'S NAME First GEORGE Middle MARTIN Last PILSON						15. MOTHER'S MAIDEN NAME First EDNA Middle HANCOCK Last PILSON						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 224-22-5793		17. INFORMANT MR. LEVI A. PILSON				ADDRESS SAME		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. _____ P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE Charles F. Donnell						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
EXAMINER'S NAME (Type) Charles F. Donnell						22b. DATE SIGNED 3/12/69						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL						23b. DATE 3-15-69		23c. NAME OF CEMETERY OR CREMATORY CHESNUT GROVE PRESBYTERIAN				
24. FUNERAL DIRECTOR J. Walter Conklin						ADDRESS 5444 BELAIR RD		25a. REC'D BY REGISTRAR MAR 17 1969		25b. REGISTRAR'S SIGNATURE William J. Judge		
23d. LOCATION (City or Town) BALTO., Co., Md.						23e. (County) (State)						

STATE OF TEXAS
COUNTY OF DALLAS

03002

DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S OFFICE
COUNTY OF DALLAS, TEXAS

Name of Deceased		Date of Death	
Sex		Age	
Race		Occupation	
Cause of Death		Manner of Death	
Place of Death		Time of Death	
Signature of Medical Examiner		Signature of Coroner	
Date of Report		Time of Report	

03606

03600

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) CHARLES B. POLESNE			2a. DATE OF DEATH Month <u>March</u> Day <u>28</u> Year <u>69</u>			2b. HOUR <u>6:45 PM</u>	
3. SEX Male		4. RACE Cau.		5. DATE OF BIRTH 1-29-1901		6. AGE (In years last birthday) <u>68</u> YRS.	
7a. BIRTHPLACE (State or foreign country) Czecho Slov.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore, Md.	
10. CITY OR TOWN OF DEATH Perry Hall		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 4334 Chapel Road		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Self employed		12b. KIND OF BUSINESS OR INDUSTRY Sand & Grave	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Md.		13b. COUNTY Balt.		13c. CITY OR TOWN Perry Hall		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER 4334 Chapel Road 21236							
14. FATHER'S NAME First John Middle Polesne Last Polesne			15. MOTHER'S MAIDEN NAME First Anna Middle Polesne Last Polesne				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 218-32-1669A		17. INFORMANT Bertha Polesne Address 4334 Chapel Road 21236			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>582 X</u> Artemia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chromi glomerulonephritis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>10 yrs +</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs +</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>68</u> , to <u>Mar</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>Mar 27 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Charles M. Kerr</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <u>3-28-69</u>			
22d. PHYSICIAN'S NAME (Type) <u>Charles M. Kerr</u>				22e. ADDRESS <u>6801 Belair Rd Bt 2 to 6</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>4-1-1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holly Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Lassahn Funeral Home 7401 Belair Road 21236</u>				25a. REC'D BY REGISTRAR DATE <u>APR 1 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles M. Kerr</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03888

[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some faint words like "RECEIVED" and "OFFICE" are visible.]

03607

CERTIFICATE OF DEATH

03601

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR P		
Charles Garlen Preston						March 26 1969			3:45M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		White		8-7-16		52 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Baltimore		U.S.A.				Baltimore Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore			St. Joseph Hospital			Western Electric					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER				
Timonium Md			Baltimore Timonium				113 Maryland Road 21093				
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Rubie A. Preston						Rose					Staab
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No			16b. SOCIAL SECURITY NO.		17. INFORMANT			Address			
			217-09-7382		Wife: Mildred			same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of liver 571.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
3-24-69			Exploratory Laparotomy			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 2-12-1969, to 3-26-1969, that (I) (we) last saw the deceased alive on 3-26-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED	
Luis Renjel, M.D.										3-26-69	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
Luis Renjel, M.D.						7620 York Road, Towson, Md. 21204					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		3-28-68		Parkwood Cemetery		Baltimore				Maryland	
24. FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Wm. Cook-Brooks Towson, Inc.						Towson, Md.		MAR 28 1969		Luis Renjel	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03050

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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03608

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03602

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Wesley Hobart Purtee			2a. DATE OF DEATH Month Day Year March 3 1969			2b. HOUR 7 A M					
3. SEX Male		4. RACE White		5. DATE OF BIRTH June 18, 1897		6. AGE (In years last birthday) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Ohio		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.					
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Balto. Co. Gen. Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Sawyer		12b. KIND OF BUSINESS OR INDUSTRY Lumber					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Owings Mills		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 10912 Reisterstown Rd.			
14. FATHER'S NAME First Middle Last George Purtee			15. MOTHER'S MAIDEN NAME First Middle Last Myrtle Cummings								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, as or unknown) No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 233-14-4629		17. INFORMANT Fanny B. Purtee 10912 Reisterstown Rd. Address Owings Mills, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Emphysema, Cor Pulmonale (c) ASCVD 20yrs 20yrs										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) probable Carcinoma Stomach.											
19a. DATE OF OPERATION 2-27-69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Hemorrhoids, hemorrhoid		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 2-15-1969, to 3-3-1969, that (I) (we) last saw the deceased alive on 3-3-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Martin J. Feldman		22c. DATE SIGNED 3/4/69		22d. PHYSICIAN'S NAME (Type) Martin J. Feldman		22e. ADDRESS Cherry Hill Rd Reisterstown Md 21136					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE March 6, 1969		23c. NAME OF CEMETERY OR CREMATORY Evergreen Mem. Gardens		23d. LOCATION (City or Town) (County) (State) Finksburg, Carroll, Md.					
24. FUNERAL DIRECTOR H. J. Zehndt		ADDRESS Owings Mills, Md.		25a. REC'D BY REGISTRAR MAR 6 1969		25b. REGISTRAR'S SIGNATURE Charles Judge					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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03609

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03603

1. DECEASED-NAME (Type or print) CHRISTOPHER			First Middle Last			2a. DATE OF DEATH* <i>March</i> Month <i>6</i> Day <i>1969</i> Year <i>6:30 AM</i>			2b. HOUR		
3. SEX Male			4. RACE White			5. DATE OF BIRTH May 15, 1895.			6. AGE (In years lost birthday) 73 YRS.		
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore, Md.		
10. CITY OR TOWN OF DEATH Reisterstown			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Bent Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Unknown			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY 135			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER 1636 Eastern Avenue			14. FATHER'S NAME First John Middle Rallis Last Karas			15. MOTHER'S MAIDEN NAME First Jean Middle Karas Last Karas					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			16b. SOCIAL SECURITY NO. 213-09-3553			17. INFORMANT Rev. Emmanuel Bouyoucas, Md. Ave. & Preston St			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma - right lung DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1621 1 year 1 week		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1-29 , 19 69 , to 3-6 , 19 69 , that (I) (we) last saw the deceased alive on 3-3 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Charles E. McWilliams M.D.			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 3-6-69		
22d. PHYSICIAN'S NAME (Type) Reisterstown Maryland 21136			22e. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 3/7/69.			23c. NAME OF CEMETERY OR CREMATORY Greek Orthodox Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore, Md.		
24. BURIAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214						25a. REC'D BY REGISTRAR DATE MAR 10 1969			25b. REGISTRAR'S SIGNATURE Charles Judge		

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CERTIFICATE OF DEATH

03604

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN 1b Arbutus	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9910 Reisterstown Road		d. STREET ADDRESS 4802 Westland Blvd. 21227	
3. NAME OF DECEASED (Type or print) First Nelva Middle Mary Last Rawlinson		4. DATE OF DEATH Month March Day 13 Year 69	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 27, 1907
9. AGE (In years last birthday) yrs. 61		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME David S. Ramsey		14. MOTHER'S MAIDEN NAME Estella May	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Edward S. Rawlinson 4802 Westland Blvd.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4124 DUE TO Cardiovascular disease - 5 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sclerotic disease - DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH short	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) auricular fibrillation - few years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-1-68 , to 3-13-69 that (I) (we) last saw the deceased alive on 3-13-69 , and that death occurred at 7 AM , from causes and on the date stated above.			
22a. SIGNATURE James B. Saffell		22b. DATE SIGNED 3-16-69	
22c. PHYSICIAN'S NAME (Type) James B. Saffell		22d. ADDRESS Reisterstown Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/17/69	
23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Pk		23d. LOCATION (City or Town) (County) (State) Glen Burnie, Md.	
24. FUNERAL DIRECTOR McCully F.H.		25a. REC'D BY REGISTRAR MAR 18 1969	
25b. REGISTRAR'S SIGNATURE Richard J. Gage		25c. ADDRESS 237 Patapsco Ave. 21225	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03611

CERTIFICATE OF DEATH

03605

1. DECEASED-NAME (Type or print) <i>Phoebe Ann Ray</i>			2a. DATE OF DEATH Month <i>March</i> Day <i>12</i> Year <i>1969</i>			2b. HOUR <i>1:45 P. M.</i>				
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>February 25, 1883</i>		6. AGE (In years last birthday) <i>86</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <i>Baltimore</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore</i> Md.				
10. CITY OR TOWN OF DEATH <i>Cockeysville</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Md. Masonic Home</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived; if institution: Residence before admission) STATE <i>md.</i>			13b. COUNTY <i>B</i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>4618 Reswick Rd.</i>	
14. FATHER'S NAME First <i>Leri</i> Middle <i>H.</i> Last <i>Sterner</i>			15. MOTHER'S MAIDEN NAME First <i>Lydian</i> Middle <i>Bailey</i> Last <i>Bailey</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>no</i> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <i>212-07-9625</i>		17. INFORMANT Address <i>Records of Md. Masonic Home Cockeysville</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Broncho-pneumonia</i> <i>4319</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cerebral Hemorrhage</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arterio-sclerotic Vas. Disease</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>14 days.</i> <i>7 days.</i> <i>5 yrs.</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <i>Dec. 1</i> , 1968, to <i>March 12</i> , 1969, that (I) (we) last saw the deceased alive on <i>March 12</i> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Carl F. Benson M.D.</i> DEGREE						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>March 12, 1969</i>		
22d. PHYSICIAN'S NAME (Type) <i>Carl F. Benson md</i>						22e. ADDRESS <i>5111 York Rd Balto. Md 21212</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>			23b. DATE <i>3-14-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>LORRAINE PARK</i>			23d. LOCATION (City or Town) (County) (State) <i>Woodlawn MARYLAND</i>		
24. FUNERAL DIRECTOR ADDRESS <i>Wm Cook-Bracks Towson</i>						25a. REC'D BY REGISTRAR DATE <i>MAR 17 1969</i>		25b. REGISTRAR'S SIGNATURE <i>V. Coleman</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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03612

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

03606

1. DECEASED-NAME (Type or print) Charles R. Read			2a. DATE OF DEATH Month March Day 22 Year 1969			2b. HOUR 7 P M			
3. SEX M		4. RACE W		5. DATE OF BIRTH July 15, 1889		6. AGE (In years last birthday) 79 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Balto., Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.			
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph's Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired-Salesman		12b. KIND OF BUSINESS OR INDUSTRY Hardware			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Worcester		13c. CITY OR TOWN Ocean City		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Gold Course Road	
14. FATHER'S NAME First ? Middle Read Last Read			15. MOTHER'S MAIDEN NAME First Unknown Middle Unknown Last Unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 213-01-61884		17. INFORMANT Mrs. Susan G. Read		Address (Same)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular tachycardia 4123 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary heart failure DUE TO, OR AS A CONSEQUENCE OF (c) Coronary artery disease								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11 min 3 months 2 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Nov , 19 67 , to March , 19 69 , that (I) (we) last saw the deceased alive on March 22 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Dr. E. P. Coffay, Jr.		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/24/69			
22d. PHYSICIAN'S NAME (Type) Dr. E. P. Coffay, Jr.		22e. ADDRESS 3100 St. Paul St.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/25/69		23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		ADDRESS 4905 York Rd. Balto., Md.		25a. RECEIVED BY REGISTRAR MAR 26 1969		25b. REGISTRAR'S SIGNATURE [Signature]			

9181, 21 July

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bioRxiv preprint doi: <https://doi.org/10.1101/151111>; this version posted April 12, 2017. The copyright holder for this preprint (which was not certified by peer review) is the author/funder, who has granted bioRxiv a license to display the preprint in perpetuity. It is made available under aCC-BY-NC-ND 4.0 International license.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 11-1-64
304 REV. 1-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03613

CERTIFICATE OF DEATH

03607

1. DECEASED-NAME (Type or print) First Middle Last Anna H. Redford			2a. DATE OF DEATH Month Day Year March 7, 1969			2b. HOUR 12:10 a.m.					
3. SEX female		4. RACE white		5. DATE OF BIRTH May 30, 1897		6. AGE (In years last birthday) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Penna.		7b. CITIZEN OF WHAT COUNTRY? U S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.					
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING GROVE STATE HOSP.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housewife			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased admission) STATE Md.		13b. CITY OR TOWN Balto.		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1621 Olive Street					
14. FATHER'S NAME First Middle Last John CASSER				15. MOTHER'S MAIDEN NAME First Middle Last Clara							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident due to thrombosis 4339 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from Jan. 21, 1969, to March 7, 1969, that (I) (we) lost saw the deceased alive on March 7, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Diomidis L. Pirovolidis				DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3-7-69			
22d. PHYSICIAN'S NAME (Type) Diomidis Pirovolidis, M.D.				22e. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 3/10/1969		23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY		23d. LOCATION (City or Town) BALTIMORE		(County)		(State) MD.	
24. FUNERAL DIRECTOR RAYMOND L. KACZOROWSKI				ADDRESS 2525 FLEET ST		25a. REC'D BY REGISTRAR MAR 12 1969		25b. REGISTRAR'S SIGNATURE			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 1-68
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03614									
03608									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH			2b. HOUR
Margaret			M		Reed	Month 3 Day 10 Year 69			M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Female		Cau		5 / 1 / 83		85 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		USA				Baltimore Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Woodlawn		2113 Sun Briar Rd		Housewife		Own Home			
13a. USUAL RESIDENCE (Where deceased admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md		Balt		Same as #10				Same as #11	
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First Middle Lost
Charles Denkin						Annie E. Flake			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
No			215-10-7152		Mrs Mary E. Fifer		Same as #11		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u>									
4123 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a):									
(b) <u>generalized arteriosclerosis</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>2-29-69</u> , 19 <u>69</u> , to <u>3-10-69</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>2-10-69</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED							
<u>Harry S Gimble</u>		3/12/69							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
Harry S Gimble, M.D.		4605 Edmondson Ave Balt Md							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		3/13/69		Moreland Park		Baltimore Co. Md			
24. FUNERAL DIRECTOR		Balt. Md 21228		25a. RECD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Wm Cook-Brooks West Inc		6212 Balt Natl Pk		DATE					

UNITED STATES DEPARTMENT OF AGRICULTURE

11330

20% COTTON

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 21c Fill in 410 3-19 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03615

03609

1. DECEASED NAME (Type or Print) JOAN MARIE RIFFLE			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 3 Day 2 Year 1969			2b. HOUR 3:00a
3. SEX Female	4. RACE White	5. DATE OF BIRTH June 17, 1947	6. AGE (In years last birthday) 21 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN. 0	2c. DATE PRONOUNCED DEAD Month March Day 2 Year 1969
7a. BIRTHPLACE (State or foreign country) Minnesota		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Balto.
10. CITY OR TOWN OF DEATH Middle River 21220		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Eastern Blvd & Wilson Pt. Rd.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Inspector		12b. KIND OF BUSINESS OR INDUSTRY Shoe Mfg. Co.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Baltimore		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13d. STREET AND NUMBER 38 S. Randolph Rd.	
14. FATHER'S NAME First Edward Middle Olson Last 			15. MOTHER'S MAIDEN NAME First Margaret Middle Boltman Last 			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO. 9/65-12/65		17. INFORMANT Ruth Wilson ADDRESS Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Injuries 8151 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) 						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year 2:11pm 3 2 69		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) passenger Subject driver in auto-fixed object coll.		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Street		21f. LOCATION Street or R.F.D. No. Eastern Blvd & Wilson Pt. Rd. City or Town Balto. County Md. State 		
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE Edward F. Wilson		EXAMINER'S NAME (Type) Edward F. Wilson, M.D.		22b. DATE SIGNED 3/2/69		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/5/69		23c. NAME OF CEMETERY OR CREMATORY Holly Hill Memorial Gardens		23d. LOCATION (City or Town) (County) (State) Baltimore Co., Maryland
24. FUNERAL DIRECTOR Bruzdinski		ADDRESS Funeral Home 1407 Eastern Ave. 21221		25a. REC'D BY REGISTRAR 6 DATE MAR 6 1969		25b. REGISTRAR'S SIGNATURE Charles Judge

21220

1990, 1991, 1992

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CSSE 2015-11-11

class: C03, J01, J02, J03

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CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) <i>Ollie Louella Robinson</i>			2a. DATE OF DEATH Month <i>March</i> Day <i>9</i> Year <i>1969</i>		2b. HOUR <i>10:30 AM</i>
3. SEX <i>Female</i>	4. RACE <i>white</i>	5. DATE OF BIRTH <i>9-15-96</i>		6. AGE (in years last birthday) <i>72</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>Va</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Baltimore County, Md.</i>		
10. CITY OR TOWN OF DEATH <i>Mount Wilson</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Mt. Wilson St. Hosp.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>House wife</i>	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>	13b. COUNTY <i>Pr. Geo.</i>	13c. CITY OR TOWN <i>Glendale, Md.</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>Box 233, Springfield Ave.</i>	
14. FATHER'S NAME First <i>John</i> Middle <i>Archart</i> Last <i>Mary</i>	15. MOTHER'S MAIDEN NAME First <i>Mary</i> Middle <i>?</i> Last <i>?</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give war or dates of service) <i>No</i>		
16b. SOCIAL SECURITY NO. <i>231-38-9439</i>		17. INFORMANT <i>Records, Mt. Wilson State Hospital</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Far Advanced pulm. Tuberculosis</i> <i>011.2</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 moos.</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>March 7, 1969</i> , to <i>March 9, 1969</i> , that (I) (we) lost the deceased alive on <i>March 9, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>W Newcomer</i>		DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>3-9-69</i>	
22d. PHYSICIAN'S NAME (Type) <i>William Newcomer, M.D.</i>		22e. ADDRESS <i>Mount Wilson, Maryland</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>March 11, 1969</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Pt Lincoln Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Colmar Manor Pro Geo Md.</i>	
24. FUNERAL DIRECTOR <i>F. Gasch's Sons</i>		ADDRESS <i>Hyattsville, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>MAR 13 1969</i>	25b. REGISTRAR'S SIGNATURE <i>J. Charles Jones</i>

Baltimore County

Mount Wilson, N.J.

2

10

Mount Wilson, N.J.

Mount Wilson, N.J.

Mount Wilson, N.J.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers on Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

03617		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03611	
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR
GERTRUDE		H.		ROPER	March 20, 1969		11:57 AM
3. SEX Female		4. RACE White		5. DATE OF BIRTH June 16, 1887		6. AGE (In years last birthday) 81 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) Florida		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.	
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) retired		12b. KIND OF BUSINESS OR INDUSTRY Medical Librarian	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER 251 Linden Ave. 21204							
14. FATHER'S NAME First Middle Last Millard Filmore Huntley		15. MOTHER'S MAIDEN NAME First Middle Last Mary Ellen Eason					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) None		17. INFORMANT Family Records Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrythmia</u> <u>4124</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (he) (this hospital) attended the deceased from <u>March 20</u> , 19 <u>69</u> , to <u>March 20</u> , 19 <u>69</u> , that (he) (we) last saw the deceased alive on <u>March 20</u> , 19 <u>69</u> , and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above, (he) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Lawrence Misanik</u>		DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 3-21-69			
22d. PHYSICIAN'S NAME (Type) Lawrence Misanik, M.D.		22e. ADDRESS 7620 York Road, Towson, Md. 21204					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Mar. 24, 1969		23c. NAME OF CEMETERY OR CREMATORY Forrest Hills Cemetery		23d. LOCATION (City or Town) (County) (State) Chattanooga, Tennessee	
24. FUNERAL DIRECTOR John Burns' Sons, Towson, Maryland		ADDRESS		25a. REC'D BY REGISTRAR DATE MAR 26 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

1280

0515 . 54 . 10000 . 10000 . 10000

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1870

1900, 1901, 1902, 1903, 1904, 1905, 1906, 1907, 1908, 1909, 1910, 1911, 1912, 1913, 1914, 1915, 1916, 1917, 1918, 1919, 1920, 1921, 1922, 1923, 1924, 1925, 1926, 1927, 1928, 1929, 1930, 1931, 1932, 1933, 1934, 1935, 1936, 1937, 1938, 1939, 1940, 1941, 1942, 1943, 1944, 1945, 1946, 1947, 1948, 1949, 1950, 1951, 1952, 1953, 1954, 1955, 1956, 1957, 1958, 1959, 1960, 1961, 1962, 1963, 1964, 1965, 1966, 1967, 1968, 1969, 1970, 1971, 1972, 1973, 1974, 1975, 1976, 1977, 1978, 1979, 1980, 1981, 1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 25

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03612

03618

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) MARIE			First C. Middle ROSASCO Last			2a. DATE OF DEATH Month 12 , Day 1969 Year			2b. HOUR 5:25 A M					
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH APRIL 5, 1934			6. AGE (In years last birthday) 34 YRS.			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH B ALTIMORE, Md.					
10. CITY OR TOWN OF DEATH TOWSON			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. JOSEPH HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOME MAKER			12b. KIND OF BUSINESS OR INDUSTRY Home					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY HARFORD			13c. CITY OR TOWN FALLSTON			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 2419 RECKORD RD. #21047		
14. FATHER'S NAME First Edward Middle Last			15. MOTHER'S MAIDEN NAME First Marie Middle Last Foehrkolb			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO.			17. INFORMANT Address Stephen Rosasco 2419 Reckford Rd. 21047		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5630 Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF Sepsis Gram (Neg.) (b) Sepsis Gram (Neg.) DUE TO, OR AS A CONSEQUENCE OF Regional enteritis (c) Regional enteritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (the hospital) attended the deceased from March , 19 69 , to March 12 , 19 69 , that (I) (we) last saw the deceased alive on March 12 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE Arthur E. Cocco						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED March 12, 1969					
22d. PHYSICIAN'S NAME (Type) Arthur E. Cocco, M.D.						22e. ADDRESS 107 E. Chase St., Baltimore, Maryland								
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE 3-15-1969			23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery			23d. LOCATION (City or Town) (County) (State) Parkville, Balto. Md.					
24. FUNERAL DIRECTOR ADDRESS Lassahn Funeral Home 7401 Belair Road 21236						25a. REC'D BY REGISTRAR MAR 17 1969			25b. REGISTRAR'S SIGNATURE Blanchard					

6120

3-21-69. M.2.D.9. Pillsbury registered. On approved. Dr. not using M.D. Report in detail. Expires 24 hours after death. TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

03619

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03613

1. DECEASED-NAME (Type or print) HELEN COLUMBIA ROUSE			2a. DATE OF DEATH 3 Month 21 Day 69 Year			2b. HOUR 3:40 P			
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH 7-4-1878		6. AGE (In years last birthday) 90 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Belair, Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE Md.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GREAT BALT MED CENT		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) homemaker		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1419 Park Ave.	
14. FATHER'S NAME First Middle Lost John Rouse			15. MOTHER'S MAIDEN NAME First Middle Lost Harriett Hanway						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no		16b. SOCIAL SECURITY NO.		17. INFORMANT Address Presbyterian Home of Md. Towson, Md. 21204					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY FAILURE 887X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) INTERTROCHANTERIC FRACTURE RT. HIP DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE 2 WEEKS									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)									
19a. DATE OF OPERATION 3-17-69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED FRACTURED HIP			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 3-7-1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) FELL					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) PRESBYTERIAN HOME		21f. LOCATION Street or R.F.D. No. City or Town County State GEORGIA COURT AND DIXIE DRIVE BALTM, MD					
22a. I certify that (this hospital) attended the deceased from 3-7- , 19 69 , to 3-21 , 19 69 , that (we) lost the deceased alive on 3-21 , 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. XXXXXX did not view the body after death.									
22b. SIGNATURE B.K. Choi M.D.				DEGREE MD		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 3-21-69	
22d. PHYSICIAN'S NAME (Type) b.k. choi, m.d.				22e. ADDRESS 6701 NORTH CHARLES ST BALT, MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 3/25/69		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		23d. LOCATION (City or Town) (County) (State) Balto., Md.			
24. FUNERAL DIRECTOR Mitchell-Wiedefeld				ADDRESS Home 6500 York Rd, Balto., Md. 21212		25a. REC'D BY REGISTRAR DATE MAR 28 1969		25b. REGISTRAR'S SIGNATURE William Judge	

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11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 841. 842. 843. 844. 845. 846. 847

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TABLE 1

10. *Journal of the American Medical Association*, 1990; 263: 1033-1037.

THE UNIVERSITY OF CHICAGO

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Figure 1

DOI: 10.1002/for

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 03620 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 03614 | | | | | | | | | |
|---|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|-----------------------------|--|--|--|--|
| Item 13 Film 411 4/14/69 kk | | | | | | | | | | CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
William Edward Russell | | | | | | | | | | 2a. DATE OF DEATH Month Day Year
3 31 69 | | | | | | | | | | 2b. HOUR
M | | | | | | | | | |
| 3. SEX
Male | | | | | 4. RACE
Caucasin | | | | | 5. DATE OF BIRTH
6-1-04 | | | | | 6. AGE (In years last birthday)
64 YRS. | | | | | IF UNDER 1 YEAR MONTHS DAYS | | | | | IF UNDER 24 HRS. HOURS MIN. | | | | |
| 7a. BIRTHPLACE (State or foreign country)
Balto | | | | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH
Baltimore Md. | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
EATONSVILLE | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Forest Haven Conv. Home | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY
News Post | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | | | 13b. COUNTY
Balto | | | | | 13c. CITY OR TOWN
Baltimore | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 13e. STREET AND NUMBER
2835 Rayner Ave. #16 | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last
John B. Russell (Deceased) | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Anne C. Martin (Deceased) | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown
No | | | | | 16b. SOCIAL SECURITY NO.
None | | | | | 17. INFORMANT Address
Clayton Russell 818 Dumbarton Ave. | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4109 ACUTE MYOCARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) ARTERIOSCLEROTIC CARDIO-VASCULAR
DUE TO, OR AS A CONSEQUENCE OF
(c) DISEASE - PULMONARY EMPHYSEMA | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19
3/26 1969 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/21 , 19 66 , to 3/31 , 19 69 , that (I) (we) last saw the deceased alive on 3/26 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
John H. Shaw | | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | 22c. DATE SIGNED
4/1/69 | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
John H. Shaw M.D. | | | | | 22e. ADDRESS
5801 Edmondson Ave. Balto. 18, Md. | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | | 23b. DATE
4-3-69 | | | | | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral Cem | | | | | 23d. LOCATION (City or Town) (County) (State)
Balto, Maryland | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | ADDRESS
Weber Funeral Home 5311 Edmondson Ave. | | | | | 25a. REC'D BY REGISTRAR
APR 3 1969 | | | | | 25b. REGISTRAR'S SIGNATURE
John H. Shaw | | | | | | | | | | | | | | |

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OFFICE OF THE ATTORNEY GENERAL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 22 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|--|--|--------------------------|--|---|---|--|-----------------------------------|--|
| 03621 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 03615 | | | | | | | | | |
| 1. DECEASED NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR |
| William Joseph Ruzicka | | | | | | 3 Month 30 Day 69 Year | | | 3 48 M |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS |
| Male | | White | | 2-27-83 | | | 66 YRS. | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | |
| Maryland | | U.S.A. | | | | | Baltimore Md. | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | St. Joseph's Hospital | | | Musician | | | Music | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER |
| Maryland | | | Baltimore | | Baltimore | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 8317 Loch Raven Blvd. |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| Veclay Ruzicka | | | Caroline | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | |
| No | | | 218-07-9080 | | Louise E. Ruzicka 8317 Loch Raven Blvd. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> | | | | | | | | | |
| 4109 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>JAN</u> , 19 <u>56</u> , to <u>MAR 30</u> , 19 <u>69</u> , that (I) (we) lost the deceased alive on <u>MAR 15</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | 22c. DATE SIGNED | | | | | | |
| Robert E. May | | | 3/30/69 | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | 22e. ADDRESS | | | | | | |
| ROBERT E. MAY, M.D. | | | 5662 THE ALAMEDA | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Inhumment | | 4-2-69 | | Lorraine Mausoleum | | Baltimore Co., Maryland | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | 25a. REC'D BY REGISTRAR DATE | | 25b. REGISTRAR'S SIGNATURE | | | |
| Wm. E. Johnson 8521 Loch Raven Blvd. 21204 | | | | APR 2 1969 | | J. Charles Judge | | | |

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1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 84

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Figure 1. The effect of the concentration of the *in vitro* culture medium on the growth of *in vitro* cultures of *Phragmites* and *Spartina* (a) and *Phragmites* and *Spartina* (b).

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800/451-3636

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pen in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03622

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03616

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|--|-------------------------|--|--|---|--|---|--|---|-----------------------------------|--|--|
| 1. DECEASED-NAME
(Type or Print) REGINA | | First L. | | Middle L. | | Last RYAN | | 2a. DATE KNOWN <input type="checkbox"/> Month Day Year March 4, 1969 | | 2b. HOUR 3:10 P | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
June 6, 1928 | | 6. AGE (In years last birthday)
40 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
Month March Day 4 , Year 1969 | |
| 7a. BIRTHPLACE (State or foreign country) Balto. Co. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Pikesville | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Old Court & Reisterstown Rds. | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN Owings Mills | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
Garrison Forest Rd. | | | |
| 14. FATHER'S NAME
William J. Dougherty Sr. | | First Middle Last | | 15. MOTHER'S MAIDEN NAME
Leona M. Wanner | | First Middle Last | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) No | | (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
214-26-5070 | | 17. INFORMANT ADDRESS
Mr. Richard C. Ryan Owings Mills, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple chest injuries
8/20
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
2:30 P.M. 3/4/ 1969 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
Driver struck by car | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
Streets | | 21f. LOCATION Street or R.F.D. No.
Old Court & Reisterstown Rds. | | City or Town
Balto. | | County
M.D | | State | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE
Edward F. Wilson | | EXAMINER'S NAME (Type)
Edward F. Wilson, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED
3/5/69 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
March 8, 69 | | 23c. NAME OF CEMETERY OR CREMATORY
Evergreen Memorial | | 23d. LOCATION (City or Town)
Finksburg, Md. | | (County) | | (State) | |
| 24. FUNERAL DIRECTOR
J. F. Eline & Sons Reisterstown, Md. | | | | ADDRESS | | 25a. REC'D BY REGISTRAR
DATE MAR 10 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

0383

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03623

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | | | | |
|--|--|--|--|---|--|---|---|---|---|--|
| 1. DECEASED-NAME
(Type or print) GUSTAV JOHN SANDS | | | 2a. DATE OF DEATH
Month MARCH Day 1 Year 1969 | | | 2b. HOUR
5¹¹ M | | | | |
| 3. SEX
MALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
JAN. 11, 1908 | | 6. AGE (In years lost birthday)
61 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign country)
N. Y. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
BALTIMORE Md. | | | | |
| 10. CITY OR TOWN OF DEATH
DUNDALK | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
2550 LIBERTY PKWY | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | | 13b. COUNTY
BALTO. | | 13c. CITY OR TOWN
DUNDALK | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
2550 LIBERTY PKWY. | |
| 14. FATHER'S NAME
First MAX Middle SANDS Last | | | 15. MOTHER'S MAIDEN NAME
First -UNK- Middle Last | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown NO (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
218-01-0175 | | 17. INFORMANT
LOCILLE H. SANDS | | | Address AS IN #13- | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cancer of the stomach
151.9
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a).
stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION
Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 6, 1969 , to MAR 4, 1969 , that (I) (we) last saw the deceased alive on Feb 28, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Benigno R. Lazaro DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | 22c. DATE SIGNED
3-3-69 | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
BENIGNO R. LAZARO | | | | | 22e. ADDRESS
59 DUNDALK AVE, DUNDALK, MD 21222 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
MAR. 4, 1969 | | 23c. NAME OF CEMETERY OR CREMATORY
GRONS. FAITH | | 23d. LOCATION (City or Town) (County) (State)
BALTO, CO. MD | | | | |
| 24. FUNERAL DIRECTOR
W. Danke Bradley ADDRESS DUNDALK, MD. 21222 | | | | | 25a. REC'D BY REGISTRAR
DATE MAR 6 1969 | | 25b. REGISTRAR'S SIGNATURE
James J. Jones | | | |

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STATE OF OHIO

IN SENATE, JANUARY 1, 1900.

1

REPORT OF THE
COMMISSIONER OF THE
BUREAU OF REVENUE
FOR THE YEAR 1899

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03624

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03618

| | | | | | | |
|---|-------------------------|---|---|---|--|--|
| 1. DECEASED-NAME
(Type or print)
Rosa Amelia Saumenig | | | 2a. DATE OF DEATH
Month 3 Day 13 Year 1969 | | | 2b. HOUR 1.45 ^A _M |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
2-9-1880 | | 6. AGE (In years lost birthday)
89 YRS. | | IF UNDER 1 YEAR
MONTHS 89 DAYS 13 HOURS 1 MIN. 45 |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. |
| 10. CITY OR TOWN OF DEATH
Lutherville | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
College Manor Ind. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
None | | 12b. KIND OF BUSINESS OR INDUSTRY
None |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
1631 Park Ave. (Plaza Apts) | |
| 14. FATHER'S NAME First Middle Last
Henry W. Saumenig | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Sarah C Saumenig | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
No | | 16b. SOCIAL SECURITY NO.
220-44-0476 | | 17. INFORMANT Address
Mr. Carroll E. Saumenig Reisterstown, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ASHD
4123
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
YEARS | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
PNEUMONIA | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
of work <input type="checkbox"/> of work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1965 , 19____, to 3/13 , 19 69 , that (I) (we) last saw the deceased alive on 3/13 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
F. M. DUGAN | | 22c. DATE SIGNED
3/13/69 | | 22d. PHYSICIAN'S NAME (Type)
F. M. DUGAN | | |
| 22e. ADDRESS
15 E. BIDDLE ST BALTIMORE | | 22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
March 15, 69 | | 23c. NAME OF CEMETERY OR CREMATORY
Druid Ridge Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Pikesville, Md. |
| 24. FUNERAL DIRECTOR
J. F. Cline & Sons | | | 25a. REC'D BY REGISTRAR
17 1969 | | | 25b. REGISTRAR'S SIGNATURE
William Dugan |

03884

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div>2</div> <div>1</div> <div>03625</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>Item 6 Film Roll 4/2/69 kk</div> <div>CERTIFICATE OF DEATH</div> <div>03619</div> | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|---|--|--|---|--|--|------------------------------------|--|--|
| 1. DECEASED-NAME
(Type or print) | | | First
MAUDE | | | Middle
A. | | | Last
SCHAMEL | | | 2a. DATE OF DEATH
3 Month 23 Day 1969 Year | | | 2b. HOUR
8:45 P. M. | | |
| 3. SEX
Female | | | 4. RACE
White | | | 5. DATE OF BIRTH
10.9.43. | | | 6. AGE (In years last birthday)
25 YRS. | | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country)
Penna | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
BALTIMORE COUNTY Md. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
TOWSON | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
CHESAPEAKE Manor TOWSON | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | | 13b. COUNTY
BALTIMORE | | | 13c. CITY OR TOWN
TOWSON | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET AND NUMBER
2625 JOPPA ROAD. | | | | | |
| 14. FATHER'S NAME
First
Theodore
Middle
Adams
Last | | | 15. MOTHER'S MAIDEN NAME
First
Laura
Middle
SPRECHER
Last | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) no | | | 16b. SOCIAL SECURITY NO.
218-40-3503A | | | 17. INFORMANT
Mrs. Carmen Reinhart | | | Address
Baltimore, Md. | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4450 Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) gangrene of Rt foot.
DUE TO, OR AS A CONSEQUENCE OF
(c) arteriosclerosis | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 week
6 weeks | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
arteriosclerosis Heart Disease | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/10/69 , 19 69 , to 3/23 , 19 69 , that (I) (we) last saw the deceased alive on 3/19/69 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Barbara A. Solomon MD | | | | | | DEGREE
MD | | | ATTENDING PHYS.
<input checked="" type="checkbox"/> | | | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED
3/24/69 | | |
| 22d. PHYSICIAN'S NAME (Type)
Barbara A. Solomon | | | | | | 22e. ADDRESS
2713 HARFORD Rd BALTO 21234 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
burial | | | 23b. DATE
3-26-69 | | | 23c. NAME OF CEMETERY OR CREMATORY
Rose Hill Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Hagerstown, Md. | | | | | | | | |
| 24. FUNERAL DIRECTOR
Minnich Funeral Home | | | | | | ADDRESS
Hagerstown, Md. | | | 25a. REC'D BY REGISTRAR
DATE MAR 27 1969 | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | |

03052

03052

DEPT. OF COMMERCE

U.S. DEPARTMENT OF COMMERCE

Section 104

XX

honesty

Latin

Theodore Adams

215-80-3502 Mrs. Carmen Robinson

08

Home Hill Cemetery, Hagerstown, Md.

2-25-60

Home Hill Cemetery, Hagerstown, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 03620 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 03620 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| Item Film 410 3/18/69 kk | | | | | | | | | | CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last <u>LENA Katzen Schapiro</u> | | | | | | | | | | 2a. DATE OF DEATH Month Day Year <u>3 9 69</u> | | | | | | | | | | 2b. HOUR <u>2:45</u> M | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX <u>F. FEMALE</u> | | | | | | | | | | 4. RACE <u>WHITE</u> | | | | | | | | | | 5. DATE OF BIRTH <u>[REDACTED]</u> | | | | | | | | | | 6. AGE (In years last birthday) <u>83</u> YRS. | | | | | | | | | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) <u>RUSSIA</u> | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. COUNTY OF DEATH <u>Baltimore</u> Md. | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH <u>Randalls town</u> | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>General Hosp.</u> | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Housewife</u> | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u> | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>md.</u> | | | | | | | | | | 13b. COUNTY <u>Baltimore</u> | | | | | | | | | | 13c. CITY OR TOWN <u>Baltimore</u> | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 13e. STREET AND NUMBER <u>2466 Keyworth Ave.</u> | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last <u>Louis Simonofsky</u> | | | | | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last <u>ANNA Perchek</u> | | | | | | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> | | | | | | | | | | 16b. SOCIAL SECURITY NO. <u>[REDACTED]</u> | | | | | | | | | | 17. INFORMANT <u>MR. BENJAMIN KATZEN</u> Address <u>6512 HOPETON AVENUE</u> | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u>
<u>4/21</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Hyperbolic Atherosclerotic Heart Disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>[REDACTED]</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>6 days</u>
<u>YEARS</u> | | | | | | | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c)
<u>Chronic Bronchitis</u>
<u>Chronic Brain Syndrome</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 19a. DATE OF OPERATION <u>3-4</u> | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Chronic Bronchitis</u> | | | | | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u> | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3-4</u> , 19 <u>67</u> , to <u>3-9</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3-9</u> , 19 <u>67</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | 22b. SIGNATURE <u>Angelica Topano</u> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | | | | | 22c. DATE SIGNED <u>3-9-69</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) <u>ANGELICA TOPANO</u> | | | | | | | | | | 22e. ADDRESS <u>BC 2A</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | | | | | | | | | 23b. DATE <u>3-10-69</u> | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY <u>WORKMEN CIRCLE</u> | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE, MARYLAND</u> | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u> | | | | | | | | | | 25a. REC'D BY REGISTRAR <u>MAR 13 1969</u> | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

03888

STATE OF MICHIGAN

03888

WITNESSES

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WIT

AT WIT

THE BENJAMIN KATLER
DOCKMAN, 8012 HOTTEN AVENUE

NO

BALTIMORE, MARYLAND

WORKMEN CIRCLE

1910-11-20

801 LEVING & CROSS, 8010 PETERSON ROAD

03627

CERTIFICATE OF DEATH

03621

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEASED-NAME (Type or print)
John Joseph Scheldt, Jr. | | | 2a. DATE OF DEATH
Month March Day 22 Year 1969 | | | 2b. HOUR
3:15 PM | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
November 29, 1920 | | 6. AGE (In years last birthday)
48 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
Baltimore, Md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | |
| 10. CITY OR TOWN OF DEATH
Towson 4 | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
St. Joseph Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
U.S. Marshall Office | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
21093 | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET AND NUMBER
2405 York Road, Timonium, Md. | | 14. FATHER'S NAME First Middle Last
John Joseph Scheldt | | 15. MOTHER'S MAIDEN NAME First Middle Last
Anna O'Brien | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service)
Yes WW 2 | | 16b. SOCIAL SECURITY NO.
219-18-7014 | | 17. INFORMANT Address
Cecilia Scheldt 2405 York Road 21093 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic carcinoma of the brain
191X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 8, 1969 , to March 22, 1969 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 22, 1969 , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
J. Banderas M.D. | | | | 22c. DATE SIGNED
March 22, 1969 | | | |
| 22d. PHYSICIAN'S NAME (Type)
Julio Banderas, M.D. | | | | 22e. ADDRESS
7620 York Road, Towson 4, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
3-25-1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Dulaney Valley Memorial | | 23d. LOCATION (City or Town) (County) (State)
Cockeysville, Maryland | |
| 24. FUNERAL DIRECTOR ADDRESS
Wm. Cook-Brooks Towson 1050 York Road 21204 | | | | 25a. REC'D BY REGISTRAR
MAR 24 1969 | | 25b. REGISTRAR'S SIGNATURE
William Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

5888

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|--|----------------------|---|--|--|--|--|--|---|
| 03628 | | CERTIFICATE OF DEATH | | | | | | 03622 | |
| 1. DECEASED-NAME
(Type or print) DORA | | | First A Middle SCHLOTENMEIER Last | | | 2a. DATE OF DEATH March 26, 1969 | | 2b. HOUR 10:23 P | |
| 3. SEX female | | | 4. RACE white | | | 5. DATE OF BIRTH 11-9-1897 | | 6. AGE (In years last birthday) 71 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) Trenton, NJ | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore Co., Md. | |
| 10. CITY OR TOWN OF DEATH Towson | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY AT HOME | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | 13b. COUNTY 44 | | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME First Thomas Middle WARD Last | | | 15. MOTHER'S MAIDEN NAME First Phoebe Middle VEIDT Last | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service) | | | |
| 16b. SOCIAL SECURITY NO. 215-22-7211 | | | 17. INFORMANT MRS. Phoebe Deegan | | | Address RT. 1 Box 492 - JARRETTVILLE HARFORD COUNTY, MD | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) 4270 Congestive heart failure. | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____ | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from March 24 , 19 69 , to March 26 , 19 69 , that (X) (we) lost the deceased alive on March 26 , 19 69 , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Samuel Lee, M.D. | | | DEGREE M.D. | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 3-27-69 | |
| 22d. PHYSICIAN'S NAME (Type) Samuel Lee, M.D. | | | 22e. ADDRESS 7620 York Road, Towson, Md. 21204 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | 23b. DATE 3-29-1969 | | | 23c. NAME OF CEMETERY OR CREMATORY HORELAND MEM. PK | | | 23d. LOCATION (City or Town) (County) (State) BALTO. Md. |
| 24. FUNERAL DIRECTOR Walter Conklin | | | ADDRESS 5444 BELAIR Rd. 21206 | | | 25a. REC'D BY REGISTRAR APR 1 1969 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|--------------------------|---|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 03629 | | | | | | | | | |
| 03623 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| Herman | | | SCHNEIDER | | | 3 Month 9 Day 69 Year | | 5:55pM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | |
| Male | | White | | 8/14/92 | | 76 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Baltimore | | Md. USA | | | | Baltimore, Md. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Towson | | Greater Balto. Med.Center | | Grain Shipper | | Railroad | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| Maryland | | | Baltimore | | | | 2802 Westfield Avenue | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| Frederick C. Schneider | | | Elizabeth Gath | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | |
| Yes 10/7/16 2/5/19 | | | 705 10 5769 | | A Mrs Alma F. Schneider Westfield Ave | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) Myocardial infarction | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| 4109 | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| Feb. 25, 69 | | Benign prostatic hypertrophy | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | Yes | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb. 11, 1969, to Mar. 9, 1969, that (I) (we) lost saw the deceased alive on March 9, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | |
| | | | | | | | | March 10, 1969 | |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS | | | | | |
| Rudiger Breitenecker, M.D. | | | | 6701 N. Charles Street, Balto. Md. 21204 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 3/13/69 | | Lorraine Park Mausoleum | | Woodlawn Maryland | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Henry Sander & Sons Inc. | | | | | | MAR 13 1969 | | | |
| Baltimore Maryland 21213 | | | | | | DATE | | | |

03882

UNITED STATES
DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03630 CERTIFICATE OF DEATH 03624

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH
a. CDUNTY <i>Baltimore</i>
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<i>Catonsville</i>
c. LENGTH OF STAY IN 1b
<i>1</i> | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<i>Parkton</i>
d. STREET ADDRESS
<i>Rayville Road</i>
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First <i>John</i> Middle <i>B.</i> Last <i>Scholl</i> | | 4. DATE OF DEATH
Month <i>March</i> Day <i>30</i> Year <i>1969</i> | |
| 5. SEX
<i>Male</i> | 6. COLOR OR RACE
<i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>Feb. 25, 1888</i> |
| 9. AGE (in years)
<i>81</i> yrs. | | 10. IF UNDER 1 YEAR
Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Baker-retired</i> | | 10b. KIND OF BUSINESS OR INDUSTRY
<i>Bakery</i> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | |
| 13. FATHER'S NAME
<i>Cyrus B. Scholl</i> | | 14. MOTHER'S MAIDEN NAME
<i>Mary Alice Bostick</i> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
<i>Yes</i> | | 16. SOCIAL SECURITY NO.
<i>212-14-0642</i> | |
| 17. INFORMANT
<i>Mrs. Elaine Hackler</i> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>4109 Acute myocardial infarction</i>
DUE TO (b) <i>Arteriosclerosis coronaria</i>
DUE TO (c) <i>DISEASE</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <i>19</i> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>12/10</i> , 19 <i>67</i> , to <i>9/30</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>3/27</i> , 19 <i>69</i> , and that death occurred at <i>3P</i> M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
<i>John H. Shaw M.D.</i> | | 22b. DATE SIGNED
<i>4/1/69</i> | |
| 22c. PHYSICIAN'S NAME (Type)
<i>John H. Shaw M.D.</i> | | 22d. ADDRESS
<i>5801 Edmonson Ave - Park 28, Md</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 23b. DATE THEREOF
<i>April 3, 1969</i> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<i>Welty's Church Cemetery</i> | | 23d. LOCATION (City, town or county) (State)
<i>Smithsburg, Maryland</i> | |
| 24. FUNERAL DIRECTOR
<i>John Burns Sons, Towson, Maryland</i> | | 25a. REC'D BY REGISTRAR
<i>APR 2 1969</i> | |
| 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | |

03030

Belgium

Belgium

Belgium

Contravention

Forest law violation

Contravention
Forest law

John

John

John

March 30, 1909

White

Feb. 25, 1908

18

White - red

White

White

124

John L. Schall

512-14-0042

Family records: London, England

John L. Schall
Mrs. Jane Schall
New York, N.Y.

John

John L. Schall, London, England

March 30, 1909

John L. Schall, London, England

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 11-410
3-26-69ans

03631

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03625

| | | | | | | | | |
|---|------------------|---|--|--|---|--|---|--|
| 1. DECEASED-NAME
(Type or Print) | | First
GERARD | Middle
LEONARD | Last
Schulmeyer | 2a. DATE KNOWN OF DEATH
<input checked="" type="checkbox"/> Month Day Year
March 20, 1969 | | | 2b. HOUR
M |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
Aug. 22, 1931 | 6. AGE (In years last birthday)
37 YRS. | IF UNDER 1 YEAR
MONTHS
DAYS | IF UNDER 24 HRS.
HOURS
MIN. | 2c. DATE PRONOUNCED DEAD
Month Day Year
March 20, 1969 | | 2d. HOUR
11:05 A.M. |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
BALTIMORE Md. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Dellsway 1584 Dellsway Road | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Store Manager | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
1584 Dellsway Road |
| 14. FATHER'S NAME
First Middle Last
Theodore G Schulmeyer | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Eva G Gunzelman | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
Yes | | (If yes give war or dates of service)
Korean | | 16b. SOCIAL SECURITY NO.
218-28-2721 | | 17. INFORMANT
Mrs Janet Schulmeyer | | ADDRESS
Same |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular disease</u>
3039
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) <u>Acute ethylism</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M.
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE
Charles S. Springate | | EXAMINER'S NAME (Type)
Charles S. Springate, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
ADDRESS (Street, city, town, or county) | | 22b. DATE SIGNED
March 20, 1969 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
3/24/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | | |
| 24. FUNERAL DIRECTOR
Leonard J Ruck Inc Baltimore, Maryland | | | | ADDRESS | | 25a. REC'D BY REGISTRAR
DATE MAR 24 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge |

1389

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03632

CERTIFICATE OF DEATH

03626

| | | | | | | | | | | | |
|---|--|---|-------|---|--|--|---|------------------------|------------------|---|------|
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Lost | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| ABRAHAM | | | L | SCHWARTZ | | 3 Month 14 Day 69 Year | | | 2:30 P | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years
last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| MALE | | CAUCASIAN | | | | 75 YRS. | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| LITHUANIA | | U.S.A. | | | | BALTIMORE, Md. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | |
| BALTIMORE | | GREAT BALT MED CENT | | TAILOR | | CLOTHING | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| MARYLAND | | | | BALTIMORE | | | | 5428 GIST AVENUE | | | |
| 14. FATHER'S NAME | | | First | Middle | Lost | 15. MOTHER'S MAIDEN NAME | | | First | Middle | Lost |
| ISAAC | | | | SCHWARTZ | | MINNIE | | | | | ? |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | | | |
| NO | | 215-05-7924A | | MRS. BESSIE SCHWARTZ, 5428 GIST AVENUE #21215 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION
4109 DUE TO, OR AS A CONSEQUENCE OF
CONDITIONS, IF ONLY, WHICH GAVE
rise to immediate cause (a),
stating the underlying cause
lost. (b) ATHEROSCLEROTIC HEART DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
CONJESTIVE HEART FAILURE DUE TO ARTEROSCLEROSIS | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> or work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-12, 1969, to 3-14, 1969, that (I) (we) last
saw the deceased alive on 3-14-1969, and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | Dost Mohammad M.D. | | | DEGREE | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S
NAME (Type) | | DOST MOHAMMAD, M.D. | | | 22e. ADDRESS | | 6701 N CHARLES ST | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| BURIAL | | 3-16-69 | | ANSHE EMUNAH (AITZ CHAIM) | | BALTIMORE, MARYLAND | | | | | |
| 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| SOL LEVINSON & BROS. | | X6010 REISTERSTOWN ROAD | | MAR 18 1969 | | J. Charles Judge | | | | | |

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THE JOURNAL

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94-61-2

STATE OF NEW YORK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
|--|--|----------------------------------|-------------------------------------|---|--|--|--|--|---|---|---|--|
| 03633 Items#1022c, FilmG411 4/7/69 km | | | | | | | | | | | | |
| 03627 | | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Anneslie | | | | c. LENGTH OF STAY IN lb
App. 17 yrs. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Anneslie | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
1120 Arran Road | | | | | | d. STREET ADDRESS
1120 Arran Road | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED
(Type or print)
IDA A. SCOTT | | | First Middle Last | | | 4. DATE OF DEATH
March 20th, 1969 | | | Month Day Year | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
March 10, 1910-59 | | | 9. AGE (In years last birthday)
59 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Homemaker | | | | 10b. KIND OF BUSINESS OR INDUSTRY
----- | | 11. BIRTHPLACE (County & State, or foreign country)
Baltimore, Md. | | | | 12. CITIZEN OF WHAT COUNTRY?
USA | | |
| 13. FATHER'S NAME
William Carr | | | | | | 14. MOTHER'S MAIDEN NAME
Louise Arnreich | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
no | | | | 16. SOCIAL SECURITY NO.
216-28-1329 | | 17. INFORMANT
Mr. Wm. L. Scott-1120 Arran Rd.-12 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
1830
IMMEDIATE CAUSE (a) Carcinomatosis
DUE TO
(b) Carcinoma of the ovary
DUE TO
(c) -----
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
15 mo. | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Nat While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 6/15, 1964 to 3/20, 1969 , that (I) (we) last saw the deceased alive on 3/19, 1969 , and that death occurred at 10:42 P.M. on the date stated above. | | | | | | | | | | | | |
| 22a. SIGNATURE
Mitchell Wiedefeld | | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
3/21/69 | | | | |
| 22c. PHYSICIAN'S NAME (Type) | | | | | | 22d. ADDRESS | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE THEREOF
3/24/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Lorraine Park | | | 23d. LOCATION (City or Town) (County) (State)
Balto. | | | | |
| 24. FUNERAL DIRECTOR
Mitchell Wiedefeld Home-6500 York Rd.12 | | | | | | 25a. REC'D BY REGISTRAR
MAR 28 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | |

03233

Baltimore

Maryland

Apr. 17, 1954

1120 Arden Road

1120 Arden Road

IRK

SCOTT

March 20, 1954

Female White

March 10, 1954 - 34

Homeowner

Baltimore, Md.

USA

William Carr

London, England

Mr. Wm. L. Scott - 1120 Arden Rd. - 12

no

United

Executive Park

3/24/54

Serial

Microfilm - Federal Home-550 York 16.12. 1954

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form M-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03634

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03628

| | | | | | | | | | | | |
|---|---------|------------------------------|--|---|------------------------------------|---|--|--|---|-------------|--------|
| 1. DECEASED-NAME
(Type or Print) | | | First | Middle | Last | 2a. DATE KNOWN OF DEATH | | | <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year | 2b. HOUR | |
| CARL HENRY SENULA | | | | | | Mar. 30, 1969 | | | 8 P. M. | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
Month Day Year | | 2d. HOUR | |
| Male | White | 4-17-10 | 58 YRS. | | | | | MAR 31 1969 | | 12:50 A. M. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Germany | | U.S.A. | | | | Baltimore | | | | Md. | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | | | 6931 Bank Street | | | Brewer | | | Beer | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| Md. | | | Baltimore | | Baltimore | | | | 6931 Bank Street | | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First | Middle | Last |
| Carl | | | | | Senula | Katherine | | | | | Nehaus |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | |
| Yes | | | W.W.II | | | Mrs. Gerda Senula | | | 6931 Bank St., Baltimore, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>A-S-C-V-Disease</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>CA of Larynx (Operated) 1965-</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | CHIEF MEDICAL EXAMINER | | | 22b. DATE SIGNED | | | | | |
| EXAMINER'S NAME (Type) | | | M.D. | | | APR 1-1969 | | | | | |
| MELVIN B. DAVIS M.D. | | | 6800 N. E. 11th St. DUNDALK MD 21222 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | | 4-2-69 | | Baltimore National | | Baltimore, Md. | | | | |
| 24. FUNERAL DIRECTOR | | | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | | |
| Nicholas T. Matthews | | | | | | 3021 Eastern Ave., Baltimore, Md. | | APR 3 1969 | | | |

03034

FOR JAIL
MAY 1950



APR 2 1950



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, on any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|--|--|--|---|---|--|--|--|---|
| 03635 | | | | | 03629 | | | | |
| 1. DECEASED-NAME
(Type or print) <u>John H Serfass</u> | | | | | 2a. DATE OF DEATH
Month <u>3</u> Day <u>30</u> Year <u>1969</u> | | | 2b. HOUR
<u>8:10</u> AM | |
| 3. SEX
<u>MALE</u> | | 4. RACE
<u>white</u> | | 5. DATE OF BIRTH
<u>9/27/23</u> | | 6. AGE (in years last birthday)
<u>46</u> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
<u>Penna.</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<u>Towson Baltimore Md.</u> | | | |
| 10. CITY OR TOWN OF DEATH
<u>Baltimore</u> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<u>CHESAPEAKE MANOR 5096 SOPPA RD.</u> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<u>Retired Draftsman</u> | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<u>MARYLAND</u> | | 13b. COUNTY
<u>Towson</u> | | 13c. CITY OR TOWN
<u>Baltimore</u> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
<u>4204 Loch Raven Dr.</u> | |
| 14. FATHER'S NAME
First <u>Samuel</u> Middle <u>Serfass</u> Last <u>Fisher</u> | | 15. MOTHER'S MAIDEN NAME
First <u>Annie</u> Middle <u>Fisher</u> Last <u>Fisher</u> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16b. SOCIAL SECURITY NO.
<u>108-05-0261</u> | | 17. INFORMANT
<u>Mrs Stella Serfass</u> | | Address
<u>Same</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS</u>
<u>185X</u> DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>CARCINOMA-PROSTATE GLAND</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>2 YEARS</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>6 MONTHS</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>A.S.C.V. DISEASE</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3024</u> , 19 <u>68</u> , to <u>MAR 30</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>MARCH 29</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Arthur Karfagin M.D.</u> | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
<u>ARTHUR KARFAGIN M.D.</u> | | 22e. ADDRESS
<u>1532 HAVENWOOD ROAD.</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE
<u>4/1/69</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Northampton Memorial Shrine</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Palmer Township Penna</u> | | | |
| 24. FUNERAL DIRECTOR
<u>Leonard J Ruck Inc. Baltimore, Maryland</u> | | | | 25a. REC'D BY REGISTRAR
<u>APR 1 1969</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

7320

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1998

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

03636

03631

| | | | | | | | |
|--|--|--|---|--|--|--|--|
| 1. DECEASED-NAME (Type or print) First Middle Last
Albert Joseph Simms | | | 2a. DATE OF DEATH Month Day Year
March 12, 1969 | | | 2b. HOUR
3:55 PM | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
1/25/1903 | | 6. AGE (In years last birthday) 66 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
Baltimore, Md. USA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
St. Joseph Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY
RESTAURANT | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
1426 Gittings Ave. # 21212 | | 14. FATHER'S NAME First Middle Last
SAMUEL H. SIMMS | | 15. MOTHER'S MAIDEN NAME First Middle Last
MELLIE MYERS | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown
UNK | | 16b. SOCIAL SECURITY NO.
--- | | 17. INFORMANT
CATHERINE SIMMS | | Address
ABOVE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/10 , 19 69 , to 3/12 , 19 69 , that (I) (we) lost saw the deceased alive on 3/12 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Camilo F. Tomboc | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
March 12, 1969 | |
| 22d. PHYSICIAN'S NAME (Type)
Camilo F. Tomboc, M.D. | | | | 22e. ADDRESS
7620 York Road, Baltimore, Md. 21204 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
3/15/69 | | 23c. NAME OF CEMETERY OR CREMATORY
BALTO. CEM. | | 23d. LOCATION (City or Town) (County) (State)
BALTO. MD. | |
| 24. FUNERAL DIRECTOR
J.G. CONNELLY SONS | | | | ADDRESS
300 MACE | | 25a. REC'D BY REGISTRAR
MAR 14 1969 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03637

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03632

| | | | | | | | | | | | |
|--|--|--|-----------------------|---|---|---|--|---|------------------|--|------|
| 1. DECEASED-NAME
(Type or print) | | First
Mary | Middle
Anna | Last
Simms | 2a. DATE OF DEATH
Month 3 Day 7 Year 69 | | 2b. HOUR
10:10 PM | | | | |
| 3. SEX
female | | 4. RACE
white | | 5. DATE OF BIRTH
5-7-1897 | | 6. AGE (In years last birthday)
71 YRS. | | IF UNDER 1 YEAR
MONTHS | OAYS | IF UNDER 24 HRS.
HOURS | MIN. |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore County Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Towson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
St. Joseph Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
2820 Garnet Rd | | | |
| 14. FATHER'S NAME
First
Benjamin | | Middle
Bucher | | Last
Laura | | 15. MOTHER'S MAIDEN NAME
First
Harple | | Middle
Harple | | Last
Harple | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
No | | 16b. SOCIAL SECURITY NO.
216-01-0091 | | 17. INFORMANT
Mrs Mary G Thomas | | Address
Same | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Massive Myocardial Infarction
4109
DUE TO, OR AS A CONSEQUENCE OF
(b) Arteriosclerotic Cardio Vascular Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.E.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-7 , 19 69 , to 3-7 , 19 69 , that (I) (we) last saw the deceased alive on 3-7 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Lilia C. Baldonado | | | | | DEGREE
M.D. | | ATTENDING PHYS.
<input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.
<input type="checkbox"/> | | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S NAME (Type)
Lilia C. Baldonado, M.D. | | | | | 22e. ADDRESS
7620 York Road, Balto, Md. 21204 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
3/11/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Parkwood | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | | | | | |
| 24. FUNERAL DIRECTOR
ADDRESS
Leonard J. Fuck Inc. Baltimore, Maryland | | | | | 25a. REC'D BY REGISTRAR
DATE
MAR 10 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | |

03880

03880

1-1-1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|---|--|---|---|---|---|
| 03638 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | 03633 | |
| Item 6 Film Roll 4/2/69 kk | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Last |
| Arthur | | | | | Sims |
| 2. DATE OF DEATH | | | Month | | Day |
| Mar | | | 19 | | 1969 |
| 3. SEX | | | 4. RACE | | 5. DATE OF BIRTH |
| male | | | white | | Mar. 17, 1987 |
| 6. AGE (In years
lost birthday) | | | IF UNDER 1 YEAR
MONTHS | | IF UNDER 24 HRS.
HOURS |
| 77 | | | 82 | | YRS. |
| 7. BIRTHPLACE (State or foreign
country) | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH |
| Maryland | | | U.S.A. | | Baltimore |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | 12. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) |
| Catonsville | | | Sumit Nursing Home | | at home |
| 13. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
omission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN |
| Maryland | | | Balto. | | Catonsville |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| Andrew | | | Sims | | 13e. STREET AND NUMBER |
| | | | Mary | | 2418 BraMarr Ave. |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, (no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT |
| no | | | 213 09 6147 | | Mrs. Gertrude Sturgeon |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u>
<u>4124</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Arteriosclerotic Cardio-vascular disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u></u>
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost. | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<u>12 hours</u>
<u>15 years</u> | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-11</u> , 19 <u>58</u> , to <u>3-18</u> , 19 <u>69</u> , that (I) (we) last
saw the deceased alive on <u>3-18</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Thomas F. Herbert M.D.</u> | | | | 22c. DATE SIGNED
<u>3-21-69</u> | |
| 22d. PHYSICIAN'S
NAME (Type)
Thomas F. Herbert M.D. | | | | 22e. ADDRESS
Ellicott City, Md. 21043 | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE
<u>3/22/69</u> | | 23c. NAME OF CEMETERY OR CREMATORY
Good Shepherd | |
| | | | | 23d. LOCATION (City or Town) (County) (State)
Ellicott City Howard Md. | |
| 24. FUNERAL DIRECTOR
Higinbotham Slack | | | | 25a. REC'D BY REGISTRAR
DATE <u>MAR 26 1969</u> | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

25960

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
|--|---------|---|---|---|---|--|---|---|---|------------------------|
| <div> <div>03639</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>03634</div> </div> | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN
OF ESTI-
DEATH MATED | | | 2b. HOUR | |
| Suzanne | | | Stewart | | | SLAGLE | | | <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year
<input checked="" type="checkbox"/> March 17, 1969 | 12:42 |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years
lost birthday) | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
Month Day Year | | 2d. HOUR |
| Female | White | 2-9-69 | YRS. 1 | 8 | | | | March 17, 1969 | | 12:42 |
| 7a. BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| Md. | | USA | | | | Baltimore | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR
INDUSTRY | | |
| Towson | | | St. Joseph Hospital | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER |
| Maryland | | | Baltimore | | | Towson Balto | | YES | | 6147 Marlora Road |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | |
| Charles William Slagle 5th | | | D'Arcy | | | Patterson | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | |
| No | | | -- | | | Charles W. Slagle 5th | | | Same | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Sudden death in infancy</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a).
stating the underlying cause
last. } (b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION
WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE
AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street,
factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | State | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion
death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | |
| ACTUAL
SIGNATURE | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | 22b. DATE SIGNED | |
| EXAMINER'S
NAME (Type) | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | ADDRESS (Street, city, town, or county) | | | 3/17/69 | |
| Ronald N. Kornblum, M.D. | | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | (State) | |
| Burial | | 3-18-69 | | Druid Ridge | | Pikesville | | | Md. | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| H.W. Jenkins & Sons Co., Balto., Md. | | | | | | MAR 18 1969 | | Charles Judge | | |

FILED
JAN 10 1953

03630

RECORD EXAMINER'S REPORT OF DEATH

| | |
|-----------------------|-----------------------------|
| NAME | CHARLES WILLIAM STANLEY JR. |
| DATE OF BIRTH | 1-10-20 |
| PLACE OF BIRTH | USA |
| DATE OF DEATH | 1-10-53 |
| PLACE OF DEATH | MEMPHIS, TENN. |
| CAUSE OF DEATH | ASSAULT |
| DEATH CERTIFICATE NO. | 1-10-53 |
| REPORTING PHYSICIAN | DR. J. H. HARRIS |
| REPORTING POLICE | DET. J. H. HARRIS |
| REPORTING CORONER | DR. J. H. HARRIS |
| REPORTING JUDGE | DR. J. H. HARRIS |
| REPORTING CLERK | DR. J. H. HARRIS |
| REPORTING NURSE | DR. J. H. HARRIS |
| REPORTING CHAPLAIN | DR. J. H. HARRIS |
| REPORTING MINISTER | DR. J. H. HARRIS |
| REPORTING RABBI | DR. J. H. HARRIS |
| REPORTING OTHER | DR. J. H. HARRIS |

CHARLES WILLIAM STANLEY JR.
1-10-20
USA
1-10-53
MEMPHIS, TENN.
ASSAULT
1-10-53
DR. J. H. HARRIS
DET. J. H. HARRIS
DR. J. H. HARRIS
DR. J. H. HARRIS
DR. J. H. HARRIS
DR. J. H. HARRIS
DR. J. H. HARRIS
DR. J. H. HARRIS
DR. J. H. HARRIS
DR. J. H. HARRIS
DR. J. H. HARRIS

RECORDED
1-10-53
INDEXED
1-10-53
FILED
1-10-53
JAN 10 1953
FBI - MEMPHIS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 11-69

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---|--|--|--|---|---|---|---|---|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 03640 | | | | | | | | | | |
| 03635 | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) Ernest P. Smith | | | | | 2a. DATE OF DEATH
Month 3 Day 11 Year 1969 | | | 2b. HOUR
6:20 A M | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
7-17-1886 | | 6. AGE (In years last birthday)
82 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | | | |
| 10. CITY OR TOWN OF DEATH
Catonsville | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Spring Grove State H. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Steel worker | | 12b. KIND OF BUSINESS OR INDUSTRY
Beth Steel | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE
Maryland | | | 13b. COUNTY
Balto | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
3012 Sparrows Pt Road. | |
| 14. FATHER'S NAME
First ? Middle unknown Last ? | | | 15. MOTHER'S MAIDEN NAME
First Fronny Middle ? Last ? | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) none (If yes give war or dates of service) | | | | |
| 16b. SOCIAL SECURITY NO.
2130705064 | | | 17. INFORMANT
The Chart Address | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary insufficiency.
4121 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Hypertensive arteriosclerotic cardiovascular years.
DUE TO, OR AS A CONSEQUENCE OF
(c) Generalized arteriosclerosis years. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)
Neutral heroin | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-4 , 1969, to 3-11 , 1969, that (I) (we) last saw the deceased alive on 3-11 , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
J. A. Perez-Balboa | | | | | DEGREE
ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3-11-1969 | | | |
| 22d. PHYSICIAN'S NAME (Type)
DR. JUAN A. PEREZ-BALBOA | | | | | 22e. ADDRESS
Spring Grove State Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
3/14/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. | | | | |
| 24. FUNERAL DIRECTOR
Schimunek Funeral Home, Inc.
3331 Brehms Lane | | | | | 25a. RECEIVED BY REGISTRAR
MAR 13 1969
DATE | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 11-63

03641

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

03636

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEASED-NAME
(Type or print) MAHIE SMITH | | First Middle Last | | 2a. DATE OF DEATH
Month 3 Day 5 Year 69 | | 2b. HOUR
10 AM | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
10/4/1887 | | 6. AGE (In years
last birthday)
81 YRS. | |
| 7a. BIRTHPLACE (State or foreign
country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore | |
| 10. CITY OR TOWN OF DEATH
Catonsville | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Shangri La Nursing Hm | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR
INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE Md | | 13b. COUNTY
Balto | | 13c. CITY OR TOWN
Balto | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
4605 Manordene Road | | 14. FATHER'S NAME
Joseph Pledge | | 15. MOTHER'S MAIDEN NAME
Anna S. | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) no | |
| 16b. SOCIAL SECURITY NO.
-- | | 17. INFORMANT
Mr. Wm. P. Smith, 932 Vanderwood Rd, 21228 | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Crown Thrombosis
4109
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Crown Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c) Chronic Arteriosclerosis | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE
unknown
unknown | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | 22a. I certify that (I) (this hospital) attended the deceased from 4/15, 1967 , to 3/5, 1969 , that (I) (we) last saw the deceased alive on 4/28, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | |
| 22b. SIGNATURE
Carl Koenig | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
3/5/69 | | | |
| 22d. PHYSICIAN'S NAME (Type)
CLIFF RATLIFF, JR | | 22e. ADDRESS
4605 EDMONDSON AVE #25 | | 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | |
| 23b. DATE
3/8/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | | 24. FUNERAL DIRECTOR
Witzke, 4101 Edmondson Ave., 21229 | |
| 25a. RECD BY REGISTRAR
MAR 7 1969 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | | |

03661

UNITED STATES OF AMERICA

RECEIVED

[Faint, mostly illegible text and markings on lined paper, possibly a ledger or form. Some words like "UNITED STATES OF AMERICA" and "RECEIVED" are visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 1/69

| 03642 | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 03637 | | | | | |
|--|--|--|--|---|--|---|--|--|--|--|--|------------------------------------|--|
| 1. DECEASED-NAME
(Type or print) | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | | | |
| First Middle Last
PHILIX SMITH | | | | Month Day Year
MARCH 28 1969 | | | | 5:50 AM | | | | | |
| 3. SEX
Male | | 4. RACE
NEGRO | | 5. DATE OF BIRTH
1/24/23 | | 6. AGE (in years
last birthday)
46 | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE (State or foreign
country)
North Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
BALTIMORE | | Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
FORT HOWARD | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
VETERANS
ADMINISTRATION HOSPITAL | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
PAINTER | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
MARYLAND | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
1630 Ashland Avenue | | | | | |
| 14. FATHER'S NAME
First Middle Last
JAMES SMITH | | 15. MOTHER'S MAIDEN NAME
First Middle Last
BLANCHE JEFFERS | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown (If yes give year or date of service)
YES WW II | | 16b. SOCIAL SECURITY NO.
216 16 1564 | | 17. INFORMANT
Address
Clinical Rcds, VA Hospital, Fort Howard, Md. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Edema
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Congestive Heart Failure
DUE TO, OR AS A CONSEQUENCE OF
(c) Post-op. Esophagectomy + Esophageal Jejunostomy
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
3 hrs
12 hrs | | | |
| 19a. DATE OF OPERATION
3/25/69 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Carcinoma Esophagus Mid | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION
Street or R.F.D. No. City or Town County State | | | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from Feb. 18 , 19 69 , to Mar. 28 , 19 69 , that (1) (we) last saw the deceased alive on Mar. 28 , 19 69 , and that in (my) (aur) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | | | | | 22b. SIGNATURE
Krishna V.S. Rao | | 22c. DATE SIGNED
3/28/69 | |
| 22d. PHYSICIAN'S NAME (Type)
KRISHNA V.S. RAO, M.D. | | 22e. ADDRESS
VA Hospital, Fort Howard, Md. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | 23b. DATE
4/1/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | | | | | | | |
| 24. FUNERAL DIRECTOR
ELLIOTT FUNERAL HOME | | ADDRESS
1129 N. Caroline St. | | 25a. APR 2 1969
DATE | | 25b. REGISTRAR'S SIGNATURE
John J. Judge | | | | | | | |

03662

03662

NAME: JAMES
ADDRESS: 1030 Ashland Avenue
CITY: JACKSON
STATE: MISSISSIPPI
COUNTRY: U.S.A.
DATE: 10/1/54
REMARKS: [illegible]

[Large section of illegible text, possibly a letter or report, with faint lines and markings.]

RECEIVED: APR 2 1954
BY: [illegible]
FROM: [illegible]
SUBJECT: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | | |
|---|--|--|---|--|--|---|--|--|--|--|--|---|--|--------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) VIOLET | | | | | | First T. | | | Middle SMITH | | | Last | | | |
| 20. DATE OF DEATH
Month March Day 28 Year 1969 | | | | | | 2b. HOUR 9:20 M. | | | | | | | | | |
| 3. SEX
Female | | | 4. RACE
Caucasian | | | 5. DATE OF BIRTH
September 6, 1894 | | | 6. AGE (In years last birthday) 74 YRS. | | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Baltimore Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH
Towson | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Chesapeake Manor N. H. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland | | | 13b. COUNTY Baltimore | | | 13c. CITY OR TOWN Baltimore | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET AND NUMBER
500 Dunkirk Road 21212 | | | |
| 14. FATHER'S NAME
William T. Tippet Sr. | | | First William Middle T. Last Tippet Sr. | | | 15. MOTHER'S MAIDEN NAME
Edna Freeman | | | First Edna Middle Freeman Last | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
219-34-4956 | | | 17. INFORMANT
John H. Winter Jr. | | | Address
1503 Maywood Ave. 21204 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR-RENAL DISEASE
4122 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/1 , 19 69 , to 3/26 , 19 69 , that (I) (we) lost the deceased alive on 3/19 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) did not view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
T. C. Siwinski | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED
3/28/69 | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Thaddeus C. Siwinski M. D. | | | | | | 22e. ADDRESS
206 West Pennsylvania Ave. 21204 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE
3-29-69 | | | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Baltimore Maryland | | | | | | |
| 24. FUNERAL DIRECTOR
Wm. Cook-Brooks Towson, Inc. Towson, Md. 21204 | | | | | | ADDRESS | | | 25a. REC'D BY REGISTRAR
APR 1 1969 | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

03803

03803

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 12

03644

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03639

CERTIFICATE OF DEATH

| | | | | | |
|--|---|--|--|---|---|
| 1. DECEASED-NAME
(Type or print) First Middle Last
Jacob Spratley | | | 2a. DATE OF DEATH
Month 3 Day 30 Year 69 | | 2b. HOUR
5:10
P M |
| 3. SEX
Male | 4. RACE
Negro | 5. DATE OF BIRTH
January 1, 1924 | | 6. AGE (In years last birthday)
45 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)
Prince Geo. Co. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore | |
| 10. CITY OR TOWN OF DEATH
Owings Mills, Md. | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Rosewood State Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Va. | | 13b. COUNTY
Hopewell | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER |
| 14. FATHER'S NAME First Middle Last
Edward Spratley | | 15. MOTHER'S MAIDEN NAME First Middle Last
Elizabeth Rives | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) (If yes give war or dates of service)
No | | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Asphyxia due to:
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Aspiration of Stomach Contents
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Terminal Terminal | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
10 yrs in skeletal and severe mental retardation Generalized Convulsions | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that I (this hospital) attended the deceased from 2 Feb 69 to 30 Mar 69 , that I (we) last saw the deceased alive on 30 Mar 69 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Richard A. Jones | | 22c. DATE SIGNED
31 Mar 69 | | 22d. PHYSICIAN'S NAME (Type)
Richard A. Jones | |
| 22e. ADDRESS
Rosewood State Hosp. | | 22f. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
4-3-69 | | 23c. NAME OF CEMETERY OR CREMATORY
not Auburn | |
| 23d. LOCATION (City or Town) (County) (State)
Bd 170. Md. | | 23e. LOCATION | | | |
| 24. FUNERAL DIRECTOR
William Wright | | 24a. ADDRESS
2700 Edmondson Ave | | 24b. PHONE NO.
Bd 21223 | |
| 25a. REC'D BY REGISTRAR
Charles Judge | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | 25c. DATE
APR 1 1969 | |

03886

UNITED STATES DEPARTMENT OF AGRICULTURE

03886



OFFICE OF THE SECRETARY

APR 1 1938

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|----------------------------------|---|---|---|--|---|---|---|---|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| 03645 CERTIFICATE OF DEATH 03640 | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <i>Baltimore</i> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i> | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Towson</i> | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Towson</i> | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<i>Towson Convalescent Home</i> | | | | | d. STREET ADDRESS
<i>1502 Dulaney Valley Road</i> | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <i>Clara</i> Middle <i>E.</i> Last <i>Stansbury</i> | | | | | 4. DATE OF DEATH
Month <i>March</i> Day <i>19</i> Year <i>1969</i> | | | | |
| 5. SEX
<i>Female</i> | 6. COLOR OR RACE
<i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<i>March 22, 1880</i> | | 9. AGE (In years last birthday)
<i>88</i> yrs. | IF UNDER 1 YEAR
Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> | IF UNDER 24 HRS.
Hours <input type="checkbox"/> Min. <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Housewife</i> | | | 10b. KIND OF BUSINESS OR INDUSTRY
<i>Cun Home</i> | | 11. BIRTHPLACE (County & State, or foreign country)
<i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | |
| 13. FATHER'S NAME
<i>Emil Wolfe</i> | | | | | 14. MOTHER'S MAIDEN NAME
<i>Kathleen Young</i> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
<i>No</i> | | | 16. SOCIAL SECURITY NO.
<i>None</i> | | 17. INFORMANT
<i>Family records</i> | | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Acute Cardiac Failure</i>
<i>4409</i> OUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis</i> OUE TO
(c) | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <i>19</i> | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>Jan</i> , 1961, to <i>March 19</i> , 1969, that (I) (we) last saw the deceased alive on <i>March 19</i> , 1969, and that death occurred at <i>2 P</i> M, from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
<i>Laurence C. Post</i> | | | | | M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<i>3/22/69</i> | | |
| 22c. PHYSICIAN'S NAME (Type)
<i>LAURENCE C. Post</i> | | | | | 22d. ADDRESS | | | | |
| 23a. BURIAL, CREMATION, or REMOVAL (Specify)
<i>Burial</i> | | | 23b. DATE THEREOF
<i>Mar. 22, 1969</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Parkwood Cemetery</i> | | 23d. LOCATION (City, town or county) (State)
<i>Parkville, Maryland</i> | | |
| 24. FUNERAL DIRECTOR
<i>John Burns' Sons, Towson, Maryland</i> | | | | | 25a. REC'D BY REGISTRAR
DATE <i>MAR 24 1969</i> | | 25b. REGISTRAR'S SIGNATURE
<i>William J. Judge</i> | | |

23230

amended

amended

amended (continued) home

amended

amended (continued) home

amended

amended (continued) home

amended

x

amended

amended

amended (continued) home

amended

amended (continued) home

amended

amended (continued) home

amended

amended (continued) home

amended

amended (continued) home

amended (continued) home

amended

amended (continued) home

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VR A15 (4)
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|--|--|--|--|--|------------------------------|---|--|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| 03646 Mary CERTIFICATE OF DEATH 03641 | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | | |
| MAY | | | FRANKLIN STANSBURY | | | March 31 1969 | | 4:11 M | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years lost birthday) | | IF UNDER 1 YEAR | | |
| F | | W | | SEPT. 12 - 1879 | | 89 YRS. | | MONTHS DAYS HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | Md. | | |
| Md | | U.S.A. | | | | BALTO. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| COCKEYSVILLE | | | MD. MASONIC HOME | | | none | | none | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | |
| MD. | | | BALTO. | | HAMPSTEAD | | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | |
| BENJAMIN - FRANKLIN | | | WILLELLA - MAXWELL | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | |
| | | | 220 54632151 | | MD. MASONIC - HOME - RECORDS | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Lobal Pneumonia | | | | | | | | | 3 days | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (b) Parkinson's Disease | | | | | | | | | 5 yrs. | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (c) | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| | | HOUR A.M. Month Day Year | | | | | | | | |
| | | P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town County State | | |
| | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | |
| 22c. DATE SIGNED | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | | |
| Carl F. Benson MD | | | | | | 514 York Rd | | Baltimore Md 21212 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| BURIAL | | 4-2-1969 | | Hampstead Cemetery | | Hampstead Maryland | | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | 25a. RECEIVED BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| W ^M Cook-Brooks Townson | | | | 1050 York Road Towson Maryland | | APR 1 1969 | | Charles Judge | | |

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03647

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03642

| | | | | | | |
|---|----------------------|---|--|---|--|--|
| 1. DECEASED-NAME
(Type or Print) Nevil Keith Stedding | | | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input type="checkbox"/> Year 3, 15 1969 | | | 2b. HOUR 2:20 PM |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH 3/23/1925 | 6. AGE (in years last birthday) 43 YRS. | IF UNDER 1 YEAR
MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> | IF UNDER 24 HRS.
HOURS <input type="checkbox"/> MIN. <input type="checkbox"/> | 2c. DATE PRONOUNCED DEAD
Month 3 Day 15 Year 1969 |
| 7a. BIRTHPLACE (State or foreign country) Mo | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore Co., Md. |
| 10. CITY OR TOWN OF DEATH Rosedale | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rosewood Trailer Pk, Rosedale | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) NIGHT CLUB OWNER | | 12b. KIND OF BUSINESS OR INDUSTRY BAR |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Rosedale | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME Nevil Stedding | | 15. MOTHER'S MAIDEN NAME Ruth Stein | | 17. INFORMANT ADDRESS Ruth Stedding 703 KEVIN Rd 21229 | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16b. SOCIAL SECURITY NO. KOREAN 213-20-3170 | | 17. INFORMANT ADDRESS Ruth Stedding 703 KEVIN Rd 21229 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4124 Arteriosclerotic cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. 19 P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | |
| ACTUAL SIGNATURE Werner U. Spitz, M.D. | | EXAMINER'S NAME (Type) | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED March 16, 1969 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE 3/21/69 | | 23c. NAME OF CEMETERY OR CREMATORY Louder PK. Cem. | | 23d. LOCATION (City or Town) (County) (State) BA/TO Md. |
| 24. FUNERAL DIRECTOR C. S. Mac Nabb 301 Frederick Rd. Balto. 21228 Md. | | | | 25a. REC'D BY REGISTRAR MAR 21 1969 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge |

HEALTH REPORT

030647

MEDICAL EXAMINER (FEDERAL CASE OF DEATH)

| | |
|-------------------------|---------------------------|
| NAME | John Doe |
| AGE | 45 |
| SEX | Male |
| DATE OF BIRTH | 12/15/1930 |
| PLACE OF BIRTH | New York, NY |
| DATE OF DEATH | 10/10/1975 |
| PLACE OF DEATH | New York, NY |
| CAUSE OF DEATH | Heart Disease |
| MANNER OF DEATH | Natural |
| TIME OF DEATH | 10:00 AM |
| LOCATION OF DEATH | Home |
| WITNESSES | John Doe, Jane Doe |
| EXAMINER'S SIGNATURE | [Signature] |
| EXAMINER'S TITLE | Medical Examiner |
| EXAMINER'S ADDRESS | 123 Main St, New York, NY |
| EXAMINER'S PHONE | 123-4567 |
| EXAMINER'S FAX | |
| EXAMINER'S E-MAIL | |
| EXAMINER'S WEBSITE | |
| EXAMINER'S SOCIAL MEDIA | |
| EXAMINER'S NOTES | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| | | | | | | | |
|---|--|--|-------|--|------|--|------------|
| 03648 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 03643 | |
| CERTIFICATE OF DEATH | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH | |
| KENNETH ELSWORTH STEWART | | | | | | March | 5 day 1969 |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | |
| Male | | White | | 8/12/07 | | 61 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH | |
| Maryland | | U.S.A. | | | | Baltimore Md. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Fort Howard | | Veterans Administration Hospital | | Salesman & U.S. Army | | Retired | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| Maryland | | | | Baltimore | | Alcazar Hotel | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | |
| Howard | | | E | Stewart | | Elizabeth A Thompson | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | |
| Yes | | PL89 | | 214 03 6073 Clinical Rcds, VA Hospital, Ft Howard, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | |
| IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA | | | | | | | |
| 1541 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| METASTATIC SQUAMOUS CELL CARCINOMA OF NECK | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| ADENOCARCINOMA OF RECTUM | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from Nov. 19, 1969, to Mar 5, 1969, that (X) (we) last saw the deceased alive on Mar 5, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (do not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | 22c. DATE SIGNED | |
| Madhav D. Barhanpurkar | | | | | | 3/6/69 | |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS | | | |
| MADHAV D. BARHANPURKAR, M.D. | | | | VA Hospital, Fort Howard, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | |
| Burial | | 3/8/1969 | | Druid Ridge Cemetery | | Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Henry W. Jenkins & Sons | | 4905 York Road Balto, Md. | | MAR 7 1969 | | Charles J. Jones | |

2230

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03649

CERTIFICATE OF DEATH

03644

| | | | | | |
|--|--|---|---|---|--|
| 1. DECEASED-NAME
(Type or print) First Middle Last
Lillian B. Stewart | | | 2a. DATE OF DEATH
Month Day Year
March 15 69 | | 2b. HOUR
M |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
7-17-1887 | | 6. AGE (In years last birthday)
81 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)
N. Y. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | |
| 10. CITY OR TOWN OF DEATH
Towson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
204 E. Joppa Rd. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Homemaker | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | 13b. COUNTY
Balto. | 13c. CITY OR TOWN
Towson | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER
204 E. Joppa Rd. |
| 14. FATHER'S NAME First Middle Last
William Brennan | | 15. MOTHER'S MAIDEN NAME First Middle Last
? Fitzpatrick | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) No | | 16b. SOCIAL SECURITY NO.
030-20-2826D | | 17. INFORMANT Address
Jean Stewart Glen Head, N. Y. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral vascular accident
4360
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c) Arterial Hypertension | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/20/68 , 19__, to 2/24 , 19 69 , that (I) (we) last saw the deceased alive on 3/7/69 , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Jamshid Hamed | | 22c. DEGREE
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22d. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (Type)
Dr. Jamshid Hamed | | 22e. ADDRESS
204 E. Joppa Rd., Towson, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | | 23b. DATE
3-17-69 | | 23c. NAME OF CEMETERY OR CREMATORY
Greenmount | |
| 23d. LOCATION (City or Town) (County) (State)
Baltimore Md. | | 23e. REGISTRAR'S SIGNATURE
Charles Judge | | | |
| 24. FUNERAL DIRECTOR
H.W. Jenkins & Sons Co., Balto., Md. | | 25a. REC'D BY REGISTRAR
DATE MAR 18 1969 | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|--|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | First
IDA | | Middle
M. | | Last
STIFLER | | 2a. DATE OF DEATH
MARCH Month 31, Day 1969 | | 2b. HOUR
5:45 A M |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
APRIL 4, 1890 | | 6. AGE (In years
last birthday)
78 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN |
| 7a. BIRTHPLACE (State or foreign
country) PENNA. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
BALTIMORE | | | | |
| 10. CITY OR TOWN OF DEATH
TOWSON | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) ST. JOSEPH HOSPITAL | | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) WORKMAN | | 12b. KIND OF BUSINESS OR
INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE MARYLAND | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
3209 ACTON RD. #21234 | | |
| 14. FATHER'S NAME First Middle Last
William MYERS | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Sarah Holtzgal | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, name (known) NO | | (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
215-54-4417 | | 17. INFORMANT
Family Records | | Address | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Abdominal carcinomatosis.
180 X DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. (b) DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 19a. DATE OF OPERATION
4-7-69 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Possible ca., cervix. | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> of work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State |
| 22a. I certify that (A) (this hospital) attended the deceased from March 4, 1969, to March 31, 1969, that (I) (we) last
saw the deceased alive on March 31, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
B. Del Carmen | | | | | | DEGREE ATTENDING
PHYS. <input type="checkbox"/> MED.
DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
March 31, 1969 | | |
| 22d. PHYSICIAN'S
NAME (Type) Benjamin DelCarmen, M.D. | | | | | | 22e. ADDRESS
7620 York Road, Towson, Md. 21204 | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE
4-3-69 | | 23c. NAME OF CEMETERY OR CREMATORY
Parkwood Cemetery | | 23d. LOCATION (City or Town)
Baltimore | | (County)
MD. | | (State) |
| 24. FUNERAL DIRECTOR
CHAS. F. EVANS & SON | | | | ADDRESS
8802 HARFORD RD | | 25a. REC'D BY REGISTRAR
APR 1 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

03262

5 12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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03651

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

03646

| | | | | | | | | | | | |
|---|--|--|--------------------------|---|---|--|--|--|----------|--|------|
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | | | 2b. HOUR | | |
| BENJAMIN | | | J. | | STOLER | MARCH 13, 1969 | | | 1 P. M. | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN | |
| MALE | | WHITE | | MAY 21, 1903 | | 65 YRS. | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | Md. | | |
| RUSSIA | | U.S.A. | | | | BALTIMORE | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| BALTIMORE | | 6998 MARSUE DR., APT. 1 C | | MERCHANT | | RETAIL | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| MARYLAND | | BALTIMORE | | BALTIMORE | | | | 6998 MARSUE DR., APT. 1 C | | | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First | Middle | Last |
| MAYER | | | | | STOLER | ANNA | | | | | ? |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | | |
| NO | | | 216-24-4895A | | MRS. SOPHIA STOLER, 6998 MARSUE DR., APT. 1 C | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u>
DUE TO, OR AS A CONSEQUENCE OF <u>arteriosclerotic heart disease</u>
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.
(b) <u>none</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>none</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>1 day</u>
<u>7 years</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<u>None</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 1</u> , 19 <u>62</u> , to <u>March 13</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>March 13</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>Manuel Levin</u> | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <u>3/14/69</u> | | | |
| 22d. PHYSICIAN'S NAME (Type) <u>MANUEL LEVIN</u> | | | | | | 22e. ADDRESS <u>6101 PARK HEIGHTS AVENUE</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| BURIAL | | 3-16-69 | | ANSHE NEISEN | | ROSEDALE, MARYLAND | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | 25a. REC'D BY REGISTRAR DATE | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | | | | MAR 18 1969 | | <u>Charles Judge</u> | | | | | |

12080

524

14-512E

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03652

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03647

| | | | | | | | | | |
|---|--|--|---|---|--|---|--|--|--|
| 1. DECEASED-NAME
(Type or print) Erma B. Stonesifer | | | 2a. DATE OF DEATH
Month March Day 1 Year 1969 | | | 2b. HOUR
3 P M | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
March 10, 1905 | | 6. AGE (In years last birthday)
63 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | | |
| 10. CITY OR TOWN OF DEATH
Reisterstown | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
418 Shirley Manor Rd. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Seamstress | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Carroll | | 13c. CITY OR TOWN
Westminster | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
124 Liberty Street | |
| 14. FATHER'S NAME First Middle Last
J. William Barnes | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Carrie Parish | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes (no, or unknown) No (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
217 18 7386 | | 17. INFORMANT
Mrs Kathryn M. Korman Address 124 Liberty St. Westminster, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Generalized carcinomatosis
1700
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma rt. jaw
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 mos.
10 yrs. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19a. DATE OF OPERATION
11-14-68 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Carcinoma. neck | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)
none | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work
none | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
none | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 2-25-69 , 19__, to 3-1-69 , 19__, that (I) (we) lost the deceased alive on 2-25-69 , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
D. D. Caples | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
3-3-69 | | | |
| 22d. PHYSICIAN'S NAME (Type)
D. D. Caples, M. D. | | | | 22e. ADDRESS
6 Hanover Rd., Reisterstown, Md. 21136 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
March 4, 1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Providence Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Gamber Carroll Md. | | | |
| 24. FUNERAL DIRECTOR
Thomas D Fletcher Address 254 East Main St. Thomas D Fletcher Funeral Home Westminster Md | | | | 25a. REC'D BY REGISTRAR
MAR 5 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

05025

CERTIFICATE OF DEATH

1954

Blank certificate form with horizontal lines for text entry.

Vertical text on the right margin, likely a filing or processing stamp.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 03653 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 03648 | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| Item# 7b, Film G410 3/24/69 km | | | | | | | | | | CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | | | First Middle Last | | | | | 2a. DATE OF DEATH | | | | | 2b. HOUR | | | | | | | | | | | | | | |
| ALEXANDRA | | | | | SZCZEPANSKI | | | | | Month 3 Day 14 Year 69 | | | | | 5:45 P M | | | | | | | | | | | | | | |
| 3. SEX | | | | | 4. RACE | | | | | 5. DATE OF BIRTH | | | | | 6. AGE (In years lost birthday) | | | | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN | | | | | | | | | |
| Female | | | | | White | | | | | 11-2-1890 | | | | | 78 YRS. | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH | | | | | Md. | | | | | | | | | |
| Poland | | | | | USA | | | | | | | | | | Baltimore | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | |
| Towson | | | | | St. Joseph's | | | | | HOUSEWIFE | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | 13b. COUNTY | | | | | 13c. CITY OR TOWN | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET AND NUMBER | | | | | | | | | |
| Md. | | | | | | | | | | Baltimore | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 2209 Bank, St., 21231 | | | | | | | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | First Middle Last | | | | | First Middle Last | | | | | | | | | | | | | | |
| Frank Prejs (deceased) | | | | | Liszewska (Deceased) | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) (If yes give war or dates of service) | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT | | | | | Address | | | | | | | | | | | | | | |
| No | | | | | 216-05-3601 | | | | | Mrs. Mary Barron | | | | | 2209 Bank Street | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) 4109 Acute myocardial infarction with acute pulmonary edema; | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic cardio-vascular disease | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (this hospital) attended the deceased from 3-6-1969, to 3-14-1969, that (X) (we) last saw the deceased alive on 3-14-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | DEGREE | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | 22c. DATE SIGNED | | | | | | | | | |
| Beatriz P. Dizon | | | | | | | | | | | | | | | | | | | | 3-14-69 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | | | | | | | | | |
| Beatriz P. Dizon, M.D. | | | | | | | | | | 6720 York Road, Towson, Md. 21204 | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | 23b. DATE | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | |
| Burial | | | | | 3-18-69 | | | | | Holy Rosary Cemetery | | | | | Dundalk, Maryland | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | ADDRESS | | | | | 25a. REC'D BY REGISTRAR | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| John M. Weber & Sons Inc. 401. S. | | | | | | | | | | Chester | | | | | MAR 17 1969 | | | | | Charles Judge | | | | | | | | | |

03023

03023

03023

PLEASE PRINT

NAME

10-1-1961

10-1-1961

10-1-1961

10-1-1961

10-1-1961

10-1-1961

03654

CERTIFICATE OF DEATH

03649

| | | | | | | | | | |
|--|--|---|---|---|--|---|--|--|--|
| 1. DECEASED-NAME
(Type or print)
Eleanor Singlewald Tarring | | | 2a. DATE OF DEATH
21 March 69 | | | 2b. HOUR
M | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
14 April 1919 | | 6. AGE (In years last birthday)
49 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Balt., Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore, Md. | | | |
| 10. CITY OR TOWN OF DEATH
Towson, Md | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
811 W. Joppa Rd. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Towson | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
811 W. Joppa Road | |
| 14. FATHER'S NAME
First Middle Last
H. Elmer Singlewald | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Eleanor Smith | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
no | | 16b. SOCIAL SECURITY NO.
215-18-0619 | | 17. INFORMANT
Address
Robert L Tarring, 811 W. Joppa, Towson, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) myocardial infarction
4109
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) arteriosclerotic c-v-D.
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
12 hours
3 yrs | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Cirrhosis of liver | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct 1968 , to 21 March, 1969 , that (I) (we) last saw the deceased alive on Oct 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
E. S. Cross Jr MD | | | | 22c. DATE SIGNED
23 March 69 | | 22d. PHYSICIAN'S NAME (Type)
ERNEST S. CROSS JR | | | |
| 23a. ADDRESS
Med Bldg Balt. Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
24 March 69 | | 23c. NAME OF CEMETERY OR CREMATORY
Dulaney Valley Mem Gdns | | 23d. LOCATION (City or Town) (County) (State)
Towson Baltimore, Md. | | | |
| 24. FUNERAL DIRECTOR
Mitchell-Wiedefeld Home | | | | ADDRESS
6500 York Road | | 25a. REC'D BY REGISTRAR
MAR 28 1969 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | |
| DATE
Balto. Md. 21212 | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03624



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03624



03655

CERTIFICATE OF DEATH

03650

| | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) MARY Caroline | | | First Middle Lost Thompson | | | 2a. DATE OF DEATH
Month 3 Day 26 Year 69 | | | 2b. HOUR
10 A M | | |
| 3. SEX
Female | | | 4. RACE
White | | | 5. DATE OF BIRTH
7-19-1892 | | | 6. AGE (lost b years lost b YRS.)
76 | | |
| 7a. BIRTHPLACE (State or foreign country)
BALTO. Md. | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Balto. | | |
| 10. CITY OR TOWN OF DEATH
Towson | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Chesapeake Manor Nursing Home | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
RET. LASHIER | | | 12b. KIND OF BUSINESS OR INDUSTRY
HARTFORD ACCIDENT & EMPLOYMENT CO. | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | | 13b. COUNTY
Baltimore | | | 13c. CITY OR TOWN
Baltimore | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 13e. STREET AND NUMBER
4226 Loch Raven Blvd. | | | 14. FATHER'S NAME
First George S Middle Thompson Lost Nettie E. Kerr | | | 15. MOTHER'S MAIDEN NAME
First Nettie E. Middle Kerr Lost Summit Ave | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service) | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
214-03-6154 | | | 17. INFORMANT
LEROY K. THOMPSON | | | Address
24 SUMMIT AVE THURMONT, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PNEUMONIA, TERMINAL
157.9 DUE TO, OR AS A CONSEQUENCE OF
(b) INTESTINAL OBSTRUCTION
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) CARCINOMA, PANCREAS
DUE TO, OR AS A CONSEQUENCE OF
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 DAYS
1 WEEK
7 MONTHS | | | | | | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION
Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from SEPT 1968 , to MARCH 1969 , that (I) (we) lost saw the deceased alive on MAR 23 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Arthur Karfagin M.D. | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED
3/26/69 | | |
| 22d. PHYSICIAN'S NAME (Type)
ARTHUR KARFAGIN M.D. | | | | | | 22e. ADDRESS
1532 HAYENWOOD ROAD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE
3/28/69 | | | 23c. NAME OF CEMETERY OR CREMATORY
Parkwood | | | 23d. LOCATION (City or Town) (County) (State)
Parkville, Balto. Co., Md. | | |
| 24. FUNERAL DIRECTOR
H.W. Jenkins & Sons Co. | | | | | | ADDRESS
4905 York Rd. Balto. 12, Md. | | | 25a. REC'D BY REGISTRAR
DATE APR 1 1969 | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

22330

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|---|--|--|--|---|---|--|--|
| 03656 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 03651 | |
| Item 166 Film 410 3/10/69 kk | | CERTIFICATE OF DEATH | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH | |
| FRANCIS KENNETH THORNTON | | | | | | 3 | 5 |
| 3. SEX | | | 4. RACE | | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | |
| MALE | | | CAUCASIAN | | 9-18-15 | 53 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| MARYLAND | | | U.S.A. | | 9. COUNTY OF DEATH
BALTIMORE | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | |
| BALTIMORE | | | GREAT BALT MED CENT | | | EQUIPMENT OPERATOR | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER |
| MARYLAND | | | | | BALTIMORE | | 5932 Glennor Road 21212 |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | |
| TILSON S. THORNTON | | | | | | MARY M. MOHLENHOFF | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | |
| YES | | | WWII | | JANE W. THORNTON 5932 GLENNOR ROAD 21212 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST & CARDIAC ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>METASTATIC CARCINOMA OF LUNG</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | 3 min

5 MONTHS |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>HEMATEMESIS, JAUNDICE 2° TO BILIARY METASTASIS</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2-14-</u> , 19 <u>69</u> , to <u>3-5</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>3-5</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>B.R. Friedlander MD</u> | | | | | 22c. DATE SIGNED
3-5-69 | | |
| 22d. PHYSICIAN'S NAME (Type)
B.R. FRIEDLANDER | | | | | 22e. ADDRESS
6701 N CHARLES ST, BALT, MD | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | |
| Burial | | 3-8-69 | | Dulaney Vallay Memorial | | Baltimore Co., Maryland | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Wm. E. Johnson 8521 Loch Raven Blvd. 21204 | | | | MAR 7 1969 | | <u>Charles Judge</u> | |

038826

1. The first part of the document is a letterhead containing the name of the organization, the date, and the name of the person to whom the letter is addressed. This section is followed by a brief introduction or opening paragraph.

2. The second part of the document is the main body of the letter, which contains the primary information or request. This section is typically divided into several paragraphs, each addressing a specific point or topic.

3. The third part of the document is a closing paragraph, which may include a summary of the main points, a statement of intent, or a request for further action. This is followed by a formal closing, such as "Sincerely" or "Respectfully," and the signature of the sender.

4. The final part of the document is a footer, which may contain contact information, a reference number, or other administrative details. This section is typically located at the bottom of the page.

9 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | | | |
|--|--|---|--|---|--|--|--|---|--|---|--|
| 03657 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 03652 | | | | | |
| 1. DECEASED-NAME
(Type or print) | | LAST
TIGNOR, | | FIRST
WILLIAM | | MIDDLE
PARIS | | 2a. DATE OF DEATH
Month Day Year
3 1 69 | | 2b. HOUR
2 PM | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
6.5.03 | | 6. AGE (In years
last birthday)
65 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign
country)
North Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
BALTIMORE CO.
RAUNDALLSTOWN Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTO COUNTY | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
BCGH | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
FARMER | | 12b. KIND OF BUSINESS OR
INDUSTRY
AGRICULTURE | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before
admission) STATE
MD | | 13b. COUNTY
BALTO | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
NO <input type="checkbox"/> YES <input type="checkbox"/> | | 13e. STREET AND NUMBER
OKLAHOMA RD. | | | |
| 14. FATHER'S NAME First Middle Last
EMMITT E. TIGNOR | | 15. MOTHER'S MAIDEN NAME First Middle Last
SARAH E. CODY | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
NO | | 16b. SOCIAL SECURITY NO.
? | | 17. INFORMANT
MRS VELVA B. TIGNOR, WIFE - ABOVE. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ASPIRATION PNEUMONIA
521.0 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ALCOHOLIC INTOXICATION
DUE TO, OR AS A CONSEQUENCE OF (c) CIRRHOSIS OF THE LIVER | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 1969 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4:00 AM 3-1-1969, to 2:PM 3-1-1969, that (I) (we) last saw the deceased alive on 3-1-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Oyuncian MD. | | DEGREE | | ATTENDING PHYS.
<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
3.1.69. | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
BARBU CALIN | | 22e. ADDRESS
ST. JOHN'S LANE ELLICOTT CITY 21043 | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | 23b. DATE
3-4-69 | | 23c. NAME OF CEMETERY OR CREMATORY
St. John's Memorial | | 23d. LOCATION (City or Town) (County) (State)
Sykesville Carroll, Md. | | | | | |
| 24. FUNERAL DIRECTOR
Harry Haight Sykesville, Md. | | | | ADDRESS | | 25a. REC'D BY REGISTRAR
DATE MAR 5 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

03557

03557

THE NATIONAL ARCHIVE

WILLIAM

WHITE

DATE

1924

1924

BOON

03557

ASPIRATION PNEUMONIA

ALCOHOLIC INTOXICATION

1. ROSS OF THE LIVER

13 12 1924

212

Copyright no

03557

24015 THE THROAT AND EARS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 7-68

03658

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03653

| | | | | | | | | | |
|---|---------|--|---------------------------------------|--|---|---|---|---|---|
| 1. DECEASED-NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH | | 2b. HOUR | | |
| Sarah | | E. | Tillman | | 3 Month 27 Day 69 Year | | M | | |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years
last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | |
| female | negro | | 11/26/16 | | 52 YRS. | | | | |
| 7a. BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED
WIDOWED | | 9. COUNTY OF DEATH | | | |
| Baltimore | | USA | | Separated | | Baltimore Md. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital,
give street address) | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | |
| Baltimore | | St. Joseph Hospital | | x | | x | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Md. | | -x | | Balto. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 2001 Madison Ave. 21217 | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First |
| | | | | | | Daisy | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) | | | (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | |
| | | | | | 215-3225 | | 1038 Baltimore Road | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>acute Myocardial infarction</u>
4109
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> ot work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | State |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost
saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Irene Jansel | | | | | DEGREE | ATTENDING
PHYS. | <input type="checkbox"/> | MED.
DIRECTOR | <input type="checkbox"/> |
| 22d. PHYSICIAN'S
NAME (Type) | | | | | 22e. ADDRESS | | | | |
| 22c. DATE SIGNED | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | (State) |
| Burial | | 330, 69 | | Mt Auburn | | Baltimore | | | |
| 24. FUNERAL DIRECTOR
Althea L. McCaig | | | | | ADDRESS
2302 W. North Ave | | 25a. REC'D BY REGISTRAR
DATE APR 1 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge |

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03654

Item 7 Film 412 5/12/69 kk

CERTIFICATE OF DEATH

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEASED-NAME
(Type or print) John C. Tilson | | | 2a. DATE OF DEATH
Month Mar Day 30 Year 69 | | | 2b. HOUR
12:00 P.M. | |
| 3. SEX
M | | 4. RACE
W | | 5. DATE OF BIRTH
6-6-95 | | 6. AGE (In years lost birthday)
73 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
Wilkes-Barre, Penn. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore County, Md. | |
| 10. CITY OR TOWN OF DEATH
Mount Wilson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Mt. Wilson State Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
machinist | | 12b. KIND OF BUSINESS OR INDUSTRY
Ordinance | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
md | | 13b. COUNTY
mont. | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
First Thomas C. Middle Tilson Last Tilson | | 15. MOTHER'S MAIDEN NAME
First Anna Middle Chase Last Ward | | 13e. STREET AND NUMBER
3815 Williams Lane, Chazy, Md. | | 13f. STREET AND NUMBER
819 Bonifant St. S.S. | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | 16b. SOCIAL SECURITY NO.
577-10-4309 | | 17. INFORMANT
John C. Tilson
(Nephew) | | Address
819 Bonifant St. S.S. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) FAR Adv. Pul. Tuberculosis
011.2
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 yr. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)
Diabetes mellitus, Arteriosclerotic Heart Dis. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. _____ P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION
Street or R.F.D. No. _____ City or Town _____ County _____ State _____ | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-27 , 19 68 , to 3-30 , 19 69 , that (I) (we) last saw the deceased alive on 3-30 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
W. Newcomer | | | | DEGREE
ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
3-30-69 | |
| 22d. PHYSICIAN'S NAME (Type)
William Newcomer, M.D. | | | | 22e. ADDRESS
Mount Wilson, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
April 3, 1969 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Gabriel's Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Hazleton, Pennsylvania | |
| 24. FUNERAL DIRECTOR
Warner E. Pumphrey, Inc. Silver Spring, Maryland | | | | 25a. REC'D BY REGISTRAR
APR 7 1969 | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

CERTIFICATE OF DEATH

Baltimore County

Wilson Senior Hospital

Mount Wilson, Maryland

William Swonger, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 03660 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 03655 | |
|---|--|---|---|---|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | |
| 1. DECEASED-NAME
(Type or print) MARTHA MARY | | | First Middle Last TOLAND | | | 2a. DATE OF DEATH
March Month 21 , Day 1969 Year | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
April 29, 1908 | | 6. AGE (In years last birthday)
60 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | |
| 10. CITY OR TOWN OF DEATH
Towson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
1217 Dulaney Valley Road | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Towson | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
1217 Dulaney Valley Road | | | | | | | |
| 14. FATHER'S NAME First Middle Last
Joseph Pietrowicz | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Agnes Kutz | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) No | | 16b. SOCIAL SECURITY NO.
----- | | 17. INFORMANT Address
Andrew J. Toland, Sr., Same as # 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CHRONIC CONGESTIVE HEART FAILURE
4123 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE
DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 MOS | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (his hospital) attended the deceased from 5/21, 1968 , to 3/21, 1969 , that (I) (we) last saw the deceased alive on 3/20, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
T.C. Siwinski | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
March 21, 1969 | |
| 22d. PHYSICIAN'S NAME (Type)
Thaddeus C. Siwinski, M.D. | | | | 22e. ADDRESS
206 W. Pennsylvania Avenue, Towson, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
Mar. 24, 1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Dulaney Valley | | 23d. LOCATION (City or Town) (County) (State)
Cockeysville, Maryland | |
| 24. FUNERAL DIRECTOR
Wm. Cook-Brooks Towson, 1050 York Road | | | | 25a. REC'D BY REGISTRAR
MAR 24 1969 | | 25b. REGISTRAR'S SIGNATURE
f Charles Judge | |

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Handwritten text, possibly a signature or title, located in the center of the page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|---|--|---|---|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 03661 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 03656 | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) <u>Lida</u> | | | First Middle Last
<u>Lida</u> <u>C</u> <u>Townsley</u> | | | 2a. DATE OF DEATH
Month Day Year
<u>March</u> <u>16</u> <u>1969</u> | | 2b. HOUR
<u>12:05</u> <u>PM</u> | |
| 3. SEX
<u>Female</u> | | 4. RACE
<u>White</u> | | 5. DATE OF BIRTH
<u>4/27/24</u> | | 6. AGE (In years last birthday)
<u>44</u> YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
<u>Baltimore</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<u>Baltimore</u> Md. | | | |
| 10. CITY OR TOWN OF DEATH
<u>Baltimore</u> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<u>St. Joseph</u> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<u>Housewife</u> | | 12b. KIND OF BUSINESS OR INDUSTRY
<u>Housewife</u> | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<u>Maryland</u> | | 13b. COUNTY
<u>Baltimore</u> | | 13c. CITY OR TOWN
<u>Towson</u> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
<u>4217 Blakely Rd.</u> <u>36</u> | |
| 14. FATHER'S NAME
First Middle Last
<u>Benjamin</u> <u>Ady</u> | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
<u>Florence</u> <u>Eicholtz</u> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
<u>No</u> | | 16b. SOCIAL SECURITY NO.
<u>218-18-8029</u> | | 17. INFORMANT
Address
<u>William P. Townsley 4217 Blakely Ave. 21236</u> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Myocardial infarction</u>
<u>4109</u>
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>1/2 hour</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July 31, 1968</u> , to <u>Aug 28, 1968</u> , that (I) (we) lost saw the deceased alive on <u>2/18</u> <u>1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Anthony J. Thomas M.D.</u> DEGREE
ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | 22c. DATE SIGNED | | | | |
| 22d. PHYSICIAN'S NAME (Type)
<u>ANTHONY J. THOMAS</u> | | | | | 22e. ADDRESS
<u>7620 YORK RD</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE
<u>3-19-1969</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Bel Air Memorial Cem.</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Bel Air</u> <u>Harford</u> <u>Md.</u> | | | |
| 24. FUNERAL DIRECTOR
<u>Lassahn Funeral Home 7401 Bel Air Road 21236</u> ADDRESS | | | | | 25a. RECEIVED BY REGISTRAR
<u>Mar 18 1969</u> DATE | | 25b. REGISTRAR'S SIGNATURE | | |

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

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| | | | | | |
|---|--|--|---|---|--|
| 1. DECEASED-NAME
(Type or print) THEODORE WILLIAM TRIBULL | | | 2a. DATE OF DEATH
Month MARCH Day 9 Year 1969 | | 2b. HOUR
12:15 AM |
| 3. SEX
MALE | 4. RACE
CAUCASIAN | 5. DATE OF BIRTH
OCTOBER 13, 1895 | | 6. AGE (In years lost birthday)
73 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country)
MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
BALTIMORE | |
| 10. CITY OR TOWN OF DEATH
FORT HOWARD | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
HOSPITAL VETERANS ADMINISTRATION | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
PAINTER | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | 13b. CITY OR TOWN
BALTIMORE | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER
3632 FREDERICK AVENUE | |
| 14. FATHER'S NAME First Middle Last
REINHOLT TRIBULL | | 15. MOTHER'S MAIDEN NAME First Middle Last
ELIZBETH REICHSTEIN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, No, or unknown) YES | | 16b. SOCIAL SECURITY NO.
220 05 0619 | | 17. INFORMANT Address
CLINICAL RECORDS, VA HOSPITAL, FT HOWARD, MD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
403 X IMMEDIATE CAUSE (a) UREMIA
DUE TO, OR AS A CONSEQUENCE OF CHRONIC ARTERIOLAR NEPHROSCLEROSIS
Conditions, if any, which gave rise to immediate cause (a).
stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
ARTERIOSCLEROSIS, GENERALIZED | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
YES | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 1/7/69 , 19____, to 3/9/69 , 19____, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 3/9/69 , 19____, and that in our (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Madhav D. Barhanpurkar | | | | 22c. DATE SIGNED
3 9 69 | |
| 22d. PHYSICIAN'S NAME (Type)
MADHAV D. BARHANPURKAR, M.D. | | | | 22e. ADDRESS
VA HOSPITAL, FORT HOWARD, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
March 12, 1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National Cemetery | |
| 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | | 24. FUNERAL DIRECTOR
3312 Frederick Ave. G. TRUMAN SCHWAB FUNERAL HOME Balto, Md. | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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UNITED STATES DEPARTMENT OF JUSTICE

WASHINGTON, D.C. 20535

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UNITED STATES DEPARTMENT OF JUSTICE

WASHINGTON, D.C. 20535

UNITED STATES DEPARTMENT OF JUSTICE

WASHINGTON, D.C. 20535

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03658

| | | | | | | | | | | | |
|---|--|--|---|---|--|---|---|--------------------------------|--|-------------------------------|--|
| 1. DECEASED-NAME
(Type or print) First Middle Last
Gertrude Elizabeth Tuerke | | | 2a. DATE OF DEATH
Month Day Year
March 15 1969 | | | 2b. HOUR
9P. M | | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
3-16-1883 | | 6. AGE (In years last birthday)
85 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Pikesville | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Rose Hill Farm | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Homemaker | | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Pikesville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
Rose Hill Farm | | |
| 14. FATHER'S NAME First Middle Last
Daniel Schwartz | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Gertrude Trabrand | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
No | | | 16b. SOCIAL SECURITY NO.
579-16-4482 | | 17. INFORMANT
William A. Tuerke | | | Address
Same | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma of breast</u>
174X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>7 mos.</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>Diabetes mellitus, A.S.H.Q. to father</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1</u> , 19 <u>58</u> , to <u>Mar 15</u> , 19 <u>69</u> , that (I) (we) lost the deceased alive on <u>March 14</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>H. F. Kleinfelter</u> | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
3/17/69 | | | | |
| 22d. PHYSICIAN'S NAME (Type) Dr. Harry F. Kleinfelter | | | | | 22e. ADDRESS
550 N. Broadway, Balto., Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
3-19-69 | | 23c. NAME OF CEMETERY OR CREMATORY
Druid Ridge | | 23d. LOCATION (City or Town) (County) (State)
Pikesville Balto. Md. | | | | | |
| 24. FUNERAL DIRECTOR
ADDRESS
H.W.Jenkins & Sons Co., Balto., Md. | | | | | 25a. REC'D BY REGISTRAR
DATE
MAR 18 1969 | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | | |

03003

DEPARTMENT OF THE ARMY, WASHINGTON, D. C.

EXHIBIT OF RECORDS

1953

March 12, 1953

Private, Alaska

3-18-1083

White

Female

Alaska

USA

Alaska

Home Hill, Alaska

Alaska

Alaska

Alaska

Alaska

Alaska

3-18-1083

Alaska

Alaska

Alaska

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|---|--|--|---|---|--|----------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 03664 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 03659 | | | | | | | | | |
| 1. DECEASED NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR |
| Rosalind Turner | | | | | | 3/15/69 Month Day Year | | | 12:15 P.M. |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS |
| F | | W | | 5/22/1893 | | | 75 YRS. | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | |
| Md | | U.S.A. | | | | | Baltimore Md. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Randallstown | | | 3508 Chapman Road | | | Housewife | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER |
| Md | | | Balto. | | Randallstown | | | | 4504 Dunland Road |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| de Royallieux | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT Address | | | |
| No | | | | | | Mr. Albert A. Turner, 3508 Chapman Road | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | 1 hour |
| IMMEDIATE CAUSE (a) Coronary occlusion | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | 3 months |
| Myxedema | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | 5 years |
| Arteriosclerotic cardiovascular disease | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| Gout, Esophagitis | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| ***** | | ***** | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | ***** | | |
| 21a. ACCIDENT WAS UNDERLYING | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | HOUR A.M. Month Day Year | | ***** | | | | | |
| (If either, notify medical examiner) | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work | | ***** | | ***** | | | | | |
| 22a. I certify that (I) did not attended the deceased from March 15, 1969, to March 17, 1969, that (I) did not saw the deceased alive on March 15, 1969, and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (I) we (did) not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | |
| M. Trabant, Jr. | | | | | | | | 3/17/69 | |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS | | | | | |
| Dr. Trabant, Jr. | | | | 1811 N. Rolling Road, Baltol. | | Md. 21228 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 3/18/69 | | Lorraine Mausoleum | | Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Witzke, 4101 Edmondson Ave. | | | | 21229 | | MAR 17 1969 | | Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|--------------------------|---|---------------------|---|--|--|---------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 03665 CERTIFICATE OF DEATH 03660 | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH | | | 2b. HOUR |
| ALICE | | | L | | VOGTMAN | 3 Month 9 Day 69 Year | | | 2:15 P M |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | |
| Female | | Cau. | | 7-18-1923 | | 45 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Harford Co | | U.S.A. | | | | Baltimore Md. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Towson | | Greater Balto. Med. Center | | Housewife | | Housewife | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | |
| Md. | | Baltimore | | Towson | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 11 Vagabond Lane 21219 | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First Middle Last |
| Harold | | | T. | | Bishop | Gladys | | | Timmons |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | Address |
| No | | | 215-34-17 | | Bonnie L. Neuwiller | | | | 5403 Marx Ave 21206 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>1621</u> <u>Carcinoma of the lung, post radiation therapy</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | edema | |
| <u>Severe fatty metamorphosis of liver, acut pericarditis and massive pulmonary/</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | State |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/22</u> , 19 <u>69</u> , to <u>3/9</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3/9</u> 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | |
| | | | | | | | | 3/10/69 | |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS | | | | | |
| Rudiger Breiteneker, M.D. | | | | 6701 N. Charles Street | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | (State) |
| Burial | | 3-13-1969 | | Abington Cemetery | | Abington | | Harford | Md. |
| 24. FUNERAL DIRECTOR | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Lassahn Funeral Home 7401 Belair Road 21236 | | | | MAR 14 1969 | | Charles Judge | | | |

22280

FOR STATE
HEALTH DEPT.

03666

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03661

| | | | | | | | | | | | | | | | | | |
|---|--|------------------|----------------|--|--|--|--|---|------|---|--|---|--|---|--------------------|--|--|
| 1. DECEASED NAME
(Type or Print) | | | First
ANTON | | | Middle
VYSKOCIL | | | Last | | | 2a. DATE KNOWN
OF ESTI-
DEATH MATED <input checked="" type="checkbox"/> 3/17/69 19 | | | 2b. HOUR
17 MIN | | |
| 3. SEX
male | | 4. RACE
white | | 5. DATE OF BIRTH
2/1/97 | | 6. AGE (in years
last birthday)
72 YRS. | | IF UNDER 1 YEAR
MONTHS OAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
Month Day Year
MAR 17 1969 | | | 2d. HOUR
145 M | | |
| 7a. BIRTHPLACE (State or foreign
country)
New York | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH
Baltimore | | | | | |
| 10. CITY OR TOWN OF DEATH
CHESAPEAKE | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Box 13, Choptank Ave. | | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired)
Restaurant | | | | 12b. KIND OF BUSINESS OR
INDUSTRY
Own Business | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
Md. | | | | 13b. COUNTY
Balto. | | | | 13c. CITY OR TOWN
EDGEMERE | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
Box 13, Choptank Ave. | | | |
| 14. FATHER'S NAME
First Middle Last
Joseph Vyskocil | | | | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Frances Prochaska | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | | | | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service)
218-32-1704 | | | | | | 17. INFORMANT
ADDRESS 21213
Marie Bowman, dght. 3517 Kentucky Ave. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4124 A-S-C-V Disease -
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | 19b. CONDITION FOR WHICH OPERATION
WAS PERFORMED?
None | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS
PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M.
P.M.
19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE
AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street,
factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No.
City or Town
County
State | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | |
| ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)
Dr. Melvin B. Davis | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
ADDRESS (Street, city, town or county)
6800 HOCNINGTON RD. BOWDLE MD 21222 BALTO. | | | | | | 22b. DATE SIGNED
3/18/69 | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | | | 23b. DATE
3/21/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer Cemetery | | | | 23d. LOCATION (City or Town)
(County)
(State)
Baltimore, Md. | | | | | | | |
| 24. FUNERAL DIRECTOR
ADDRESS
Schimunek Funeral Home, Inc.
3331 Brehms Lane | | | | | | 25a. REC'D BY REGISTRAR
DATE
MAR 24 1969 | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH EXAMINER
DATE OF EXAMINATION
PLACE OF EXAMINATION
NAME OF EXAMINEE
SEX
AGE
OCCUPATION
EDUCATION
MARRIAGE
CHILDREN
RELIGION
RACE
COLOR
HEIGHT
WEIGHT
TEMPERATURE
PULSE
BLOOD PRESSURE
VITALS
PHYSICAL EXAMINATION
LABORATORY TESTS
X-RAY
DIAGNOSIS
TREATMENT
PROGNOSIS
REMARKS
SIGNATURE OF EXAMINER
DATE OF REPORT

03688

| | | | |
|-----------------------|--|----------------------|--|
| NAME OF EXAMINEE | | DATE OF EXAMINATION | |
| SEX | | AGE | |
| OCCUPATION | | EDUCATION | |
| MARRIAGE | | CHILDREN | |
| RELIGION | | RACE | |
| COLOR | | HEIGHT | |
| WEIGHT | | TEMPERATURE | |
| PULSE | | BLOOD PRESSURE | |
| VITALS | | PHYSICAL EXAMINATION | |
| LABORATORY TESTS | | X-RAY | |
| DIAGNOSIS | | TREATMENT | |
| PROGNOSIS | | REMARKS | |
| SIGNATURE OF EXAMINER | | DATE OF REPORT | |

4
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|--|--|---|------------------------------------|---|--|---|---------------|
| 03667 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 03662 | |
| CERTIFICATE OF DEATH | | | | | | | |
| 1. DECEASED-NAME
(Type or print) <i>EMILY</i> | | | First Middle Last
<i>WAGNER</i> | | 2a. DATE OF DEATH
<i>3</i> Month <i>14</i> Day <i>69</i> Year | | 2b. HOUR
M |
| 3. SEX
<i>F</i> | | 4. RACE
<i>W.</i> | | 5. DATE OF BIRTH
<i>SEPT. 16, 1890</i> | | 6. AGE (In years last birthday)
<i>78</i> YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
<i>PENNA.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>BALTIMORE</i> | |
| 10. CITY OR TOWN OF DEATH
<i>Pikesville</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>218 SUDDBROOK LANE</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>Md</i> | | 13b. COUNTY
<i>BALTO</i> | | 13c. CITY OR TOWN
<i>CATONSVILLE</i> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET AND NUMBER | | 14. FATHER'S NAME
First Middle Last
<i>CHRISTIAN</i> <i>GINDELE</i> | | 15. MOTHER'S MAIDEN NAME
First Middle Last
<i>ELIZABETH</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) <i>NO</i> | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Dehydration + Malnutrition secondary</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <i>to advanced cerebral arteriosclerosis</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Residual of Cerebral Vascular Accident</i> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>June</i> , 19 <i>67</i> , to <i>14 March</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>14 March</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>William J. Bryson</i> | | | | DEGREE
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22b. PHYSICIAN'S NAME (Type)
<i>Bryson</i> | | | | 22e. ADDRESS
<i>4605 Edmondson Ave</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
<i>3-17-69</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Rossain Mausoleum</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Woodlawn Balto - Md</i> | |
| 24. FUNERAL DIRECTOR
<i>E. S. MacNabb</i> | | | | ADDRESS
<i>301 Frederick Rd Balto Md 21228</i> | | 25a. REC'D BY REGISTRAR
<i>DATE MAR 18 1969</i> | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<i>Charles J. [unclear]</i> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

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03668

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03663

| | | | | | | | | | |
|---|--|--|--|---|---|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) First Middle Last
Margaret L. Walsh | | | 2a. DATE OF DEATH
Month Day Year
31 22 1969 | | | 2b. HOUR A
12.01M | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
Nov. 22, 1885 | | 6. AGE (In years last birthday)
83 YRS. | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Balto. Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | | |
| 10. CITY OR TOWN OF DEATH
Towson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Holly Hill Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
clerk Register | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
713 Melville Ave | |
| 14. FATHER'S NAME First Middle Last
James J Walsh | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Brigid Mooney | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No. | | | 16b. SOCIAL SECURITY NO.
216-10-7107 | | 17. INFORMANT Address
Mrs. Rose Walsh 1205 Register Ave | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Cardiac Failure
4409 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 10, 1968 to March 22, 1969 , that (I) (we) saw the deceased alive on March 22, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Laurence C. Post M.D. | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
3/24/69 | | | |
| 22d. PHYSICIAN'S NAME (Type)
LAURENCE C. Post | | | | 22e. ADDRESS
6805 York Rd | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
3/24, 1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Cathedral Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Balto. Balto. Md | | | |
| 24. FUNERAL DIRECTOR ADDRESS
Mitchell Wiedefeld Home 6500 York Rd. | | | | 25a. REC'D BY REGISTRAR
MAR 28 1969 | | 25b. REGISTRAR'S SIGNATURE
William J. ... | | | |

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DEPARTMENT OF COMMERCE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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|--|--------------|--|---|--|---|
| 03669 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | 03664 | |
| CERTIFICATE OF DEATH | | | | | |
| 1. DECEASED-NAME
(Type or print) First Middle Last
Ottilia P. Walter | | | 2a. DATE OF DEATH
March Month 18 Day 1969 Year | | 2b. HOUR
M |
| 3. SEX
F | 4. RACE
W | | 5. DATE OF BIRTH
June 28, 1889 | | 6. AGE (In years last birthday)
79 YRS. |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. |
| 10. CITY OR TOWN OF DEATH
Catonsville | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Summitt Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Clerk | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
3386 Dulaney Street 21229 |
| 14. FATHER'S NAME First Middle Last
August Walter | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Hannah Buschman | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
No (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
216-05-3627A | | 17. INFORMANT Address
Mrs. Nettie W. Grubbs, 3386 Dulaney St. 21229 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Dehydration & Malnutrition</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Cerebral Vascular accident</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Advanced Atherosclerosis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 1968</u> to <u>18 March 1969</u> , that (I) (we) last saw the deceased alive on <u>18 March 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>William J. Bryson M.D.</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22c. DATE SIGNED
<u>20 March 69</u> | |
| 22d. PHYSICIAN'S NAME (Type)
William J. Bryson | | | | 22e. ADDRESS
4605 Edmondson Ave., Balto. Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
3-21-1969 | 23c. NAME OF CEMETERY OR CREMATORY
Lorraine Park Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Woodlawn, Maryland |
| 24. FUNERAL DIRECTOR
Howard H. Hubbard, 4107 Wilkens Ave. 21229 | | | 25a. REC'D BY REGISTRAR
DATE MAR 24 1969 | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| 03670 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 03665 | |
| CERTIFICATE OF DEATH | | | | | | | |
| 1. DECEASED-NAME (Type or print) BESSIE R WARE | | | 2a. DATE OF DEATH 3 Month 2 Day 69 Year | | | 2b. HOUR 3:30 P.M. | |
| 3. SEX F | | 4. RACE W | | 5. DATE OF BIRTH 6 April 1876 | | 6. AGE (In years last birthday) 92 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) WESTMINSTER MD | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH BALTIMORE Md. | |
| 10. CITY OR TOWN OF DEATH CATONSVILLE | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SUMMIT NURS. HOME | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) SEAMSTRESS | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD | | 13b. COUNTY CATONSVILLE | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET AND NUMBER 5027 WEST HILLS RD | | 14. FATHER'S NAME First GEREMIAH Middle MYERS Last UNKNOWN | | 15. MOTHER'S MAIDEN NAME First UNKNOWN Middle UNKNOWN Last UNKNOWN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. 219-10-5094 | | 17. INFORMANT CHART | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) TACHYCARDIA
4124 DUE TO, OR AS A CONSEQUENCE OF CONGESTIVE HEART FAILURE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASCVD
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/16 , 19 69 , to 3/2 , 19 69 , that (I) (we) last saw the deceased alive on 3/1 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE E. KASAITIS, MD | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (Type) E. KASAITIS, MD | | | | 22e. ADDRESS 1801 Frederick Rd Baltimore Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE 3-5-69 | | 23c. NAME OF CEMETERY OR CREMATORY MOOREHEAD MEMORIAL | | 23d. LOCATION (City or Town) (County) (State) UNION MILLS MD | |
| 24. FUNERAL DIRECTOR WEBER FUNERAL HOME 5311 EDMONDSON AVE. | | | | 25a. REC'D BY REGISTRAR MAR 6 1969 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | |

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| OFFICE OF THE CHIEF OF STAFF | |
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1-66

03671

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03666

| | | | | | | | | | |
|---|--|---|------------------------|---|---|---|--|--|----------------------------------|
| 1. DECEASED-NAME
(Type or print) Oakley | | First S. | Middle Warfield | Last | 2a. DATE OF DEATH
Month March Day 20 Year 1969 | | 2b. HOUR 4:05 MIN A. | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
Nov. 7, 1896 | | 6. AGE (In years last birthday)
72 YRS. | | IF UNDER 1 YEAR
MONTHS
DAYS | IF UNDER 24 HRS.
HOURS
MIN |
| 7a. BIRTHPLACE (State or foreign country)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore County Md. | | | |
| 10. CITY OR TOWN OF DEATH
Towson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Chesapeake Manor | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Textile worker | | 12b. KIND OF BUSINESS OR INDUSTRY
Hooper Mill | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
2050 Druid Park Drive | |
| 14. FATHER'S NAME First Henry | | Middle R. | | Last Warfield | | 15. MOTHER'S MAIDEN NAME First Josephine | | Middle M. Last Poole | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> or unknown <input type="checkbox"/> (If yes give war or dates of service)
WW I | | 16b. SOCIAL SECURITY NO.
216-09-45794 | | 17. INFORMANT Address Drive
Mrs. Flora A. Warfield-2050 Druid Park | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage
4319
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Generalized Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 wks
10 yrs | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 18, 1947 to March 20, 1969 , that (I) (we) last saw the deceased alive on March 20, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Charles F. O'Donnell | | | | DEGREE ATTENDING PHYS.
<input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
8/21/69 | | | |
| 22d. PHYSICIAN'S NAME (Type) CHARLES F. O'DONNELL | | | | 22e. ADDRESS
7501 YORK Rd. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
3/22/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Woodlawn, Md. | | | |
| 24. FUNERAL DIRECTOR
Austin E. Donovan-3818 Roland Ave. | | | | ADDRESS | | 25a. REC'D BY REGISTRAR
DATE MAR 24 1969 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|--|--|--------------------------|---|---|---|--|-----------------------------------|--|
| 03672 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR |
| Margaret Lillian Welch | | | | | | March 14 1969 | | | M |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | |
| F | | W | | Aug. 2, 1905 | | 63 YRS. | | MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Maryland | | U. S. A. | | | | Baltimore | | Md. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | |
| Arbutus | | 5140 Westland Blvd. | | Housewife | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | Baltimore | | Arbutus | | | | 5140 Westland Blvd. 21227 | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| Albert E. Wallis | | | Margaret Samules | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | |
| No. | | | None | | Glenn R. Welch, 5140 Westland Blvd. 21227 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Generalized CARCINOMATOSIS
1991
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ORIGINAL SITE Undetermined
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | 1 YR + |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | HOUR A.M. Month Day Year
P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/13, 1969, to 3/14, 1969, that (I) (we) last saw the deceased alive on 3/13, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | | | |
| Thomas E. Roach | | | | 5550 Baltimore National Pike | | 3/14/69 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 3-17-69 | | New Cathedral Cemetery | | Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Howard H. Hubbard 4107 Wilkens Avenue 21229 | | | | | | MAR 17 1969 | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|---|---|---|---|--|---|--------------------------------|-------|-------------------------------|--------|--|------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | | | |
| 03673 | | | | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | |
| 03668 | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | | Middle | | Last | | 2a. DATE OF DEATH | | 2b. HOUR | | | | | | |
| Howard | | | C | | Wellener | | | | Month 3 Day 17 Year 69 | | 7:20 M | | | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN | | | | |
| Male | | | White | | | May 21, 1896 | | | 72 YRS. | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | | | | | |
| Maryland | | | U.S.A. | | | | | | Baltimore Md. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | |
| Towson | | | Greater Balto. Medical Ctr. | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | | | | | | |
| Maryland | | | Balto. | | | Parkville | | | | 7709 Old Harford Rd | | | | | | | |
| 14. FATHER'S NAME | | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | | First | | Middle | | Last | |
| Bazil | | | S | | Wellener | | | | Kate | | | W | | Hamill | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | | | | | | | |
| Yes | | | WW 1 | | | 212-01-0523 | | | Mrs. Grace G Wellener | | | | Same | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>massive MYOCARDIAL INFARCT</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>CORONARY ARTERIO SCLEROSIS</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>15 YRS</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>1 HOUR</u> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/12</u> , 19 <u>67</u> , to <u>3/17</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3/17</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>John H. Herschfeld M.D.</u> | | | | | | DEGREE
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<u>3/18/1969</u> | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
John H Herschfeld M.D. | | | | | | 22e. ADDRESS
6919 Harford Rd Baltimore, Md | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE
3/20/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park | | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | | | | | | | | | |
| 24. FUNERAL DIRECTOR
Leonard J Ruck Inc. Baltimore, Maryland | | | | | | 25a. REC'D BY REGISTRAR
MAR 18 1969 | | 25b. REGISTRAR'S SIGNATURE
<u>Charles J. Jones</u> | | | | | | | | | |

25080

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 03674 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | CERTIFICATE OF DEATH | | 03669 | |
|--|--|---|--|---|--|---|--|---|--|
| 1. DECEASED-NAME
(Type or print) NEVIN L. WELLING | | | | | | 2a. DATE OF DEATH
Month MAR Day 19 Year 1969 | | 2b. HOUR
M | |
| 3. SEX
M | | 4. RACE
W | | 5. DATE OF BIRTH
MAY 23 1894 | | 6. AGE (In years last birthday)
74 YRS. | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | |
| 7a. BIRTHPLACE (State or foreign country)
MO | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
BALTO | | | |
| 10. CITY OR TOWN OF DEATH
ESSEX | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
322 STEMMERS RUN | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
ELECTRICIAN | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MO | | 13b. COUNTY
BALTO | | 13c. CITY OR TOWN
ESSEX | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
322 STEMMERS RUN | |
| 14. FATHER'S NAME
First JAMES D. Middle WELLING Last JAMES D. WELLING | | | | 15. MOTHER'S MAIDEN NAME
First SUSAN Middle STANBURY Last SUSAN STANBURY | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, na, or unknown) UNK (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
216-07-1416 | | 17. INFORMANT
Address FRANCIS HUTCHISON ABOVE | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 1533 Carcinomatosis - Primary in sigmoid.
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 months | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
None | | | | | | | | | |
| 19a. DATE OF OPERATION
None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Transverse Colostomy | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-10 , 19 69 , to 3-20 , 19 69 , that (I) (we) last saw the deceased alive on 3-18 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Leopoldo Gruss M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22c. DATE SIGNED
3-20-69 | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Leopoldo GRUSS M.D. | | | | 22e. ADDRESS
405- Femmers Rd Bal | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
3/22/69 | | 23c. NAME OF CEMETERY OR CREMATORY
WOODLAWN | | 23d. LOCATION (City or Town) (County) (State)
BALTO MD. | | | |
| 24. FUNERAL DIRECTOR
J.G. CONNELLY | | | | 25a. REC'D BY REGISTRAR
DATE MAR 24 1969 | | 25b. REGISTRAR'S SIGNATURE
Johnas Judge | | | |

03634

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03675

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03670

| | | | | | | | |
|---|--|---|---|---|--|--|--|
| 1. DECEASED-NAME
(Type or print)
Charles E. Wemple | | | 2a. DATE OF DEATH
3-18-69 Month Day Year | | | 2b. HOUR
3:45 P M | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
10-23-78 | | 6. AGE (In years last birthday)
90 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | |
| 10. CITY OR TOWN OF DEATH
Towson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Holly Hill Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Ret. Sell Employee | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Towson | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET AND NUMBER
336 Stevenson La. | | | | | | | |
| 14. FATHER'S NAME First Middle Lost
McKinney Wemple | | | 15. MOTHER'S MAIDEN NAME First Middle Lost
Eliza Jakeway | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)
No | | 16b. SOCIAL SECURITY NO.
233-18-8253 | | 17. INFORMANT Address
Ella K. Wilson, 336 Stevenson La. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u>
DUE TO, OR AS A CONSEQUENCE OF <u>Arteriosclerosis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF _____
(c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 months |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 10</u> , 19 <u>67</u> , to <u>March 18</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>March 18</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Laurence C. Post M.D.</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22c. DATE SIGNED
3/19/69 | | | |
| 22d. PHYSICIAN'S NAME (Type)
Laurence C. Post, M.D. | | | | 22e. ADDRESS
6805 York Rd. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
3/22/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Greenwood | | 23d. LOCATION (City or Town) (County) (State)
Wheeling, W. Va. | |
| 24. FUNERAL DIRECTOR
Leonard J. Ruck, Inc., 5305 Harford Rd. | | | | 25a. REC'D BY REGISTRAR
DATE MAR 19 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

83877

UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT

| | | | |
|---------------------|--|----------------------|--|
| 1. NAME OF LAND | | 2. LOCATION | |
| 3. DATE OF SURVEY | | 4. NAME OF SURVEYOR | |
| 5. NAME OF CLAIMANT | | 6. NAME OF WITNESS | |
| 7. NAME OF WITNESS | | 8. NAME OF WITNESS | |
| 9. NAME OF WITNESS | | 10. NAME OF WITNESS | |
| 11. NAME OF WITNESS | | 12. NAME OF WITNESS | |
| 13. NAME OF WITNESS | | 14. NAME OF WITNESS | |
| 15. NAME OF WITNESS | | 16. NAME OF WITNESS | |
| 17. NAME OF WITNESS | | 18. NAME OF WITNESS | |
| 19. NAME OF WITNESS | | 20. NAME OF WITNESS | |
| 21. NAME OF WITNESS | | 22. NAME OF WITNESS | |
| 23. NAME OF WITNESS | | 24. NAME OF WITNESS | |
| 25. NAME OF WITNESS | | 26. NAME OF WITNESS | |
| 27. NAME OF WITNESS | | 28. NAME OF WITNESS | |
| 29. NAME OF WITNESS | | 30. NAME OF WITNESS | |
| 31. NAME OF WITNESS | | 32. NAME OF WITNESS | |
| 33. NAME OF WITNESS | | 34. NAME OF WITNESS | |
| 35. NAME OF WITNESS | | 36. NAME OF WITNESS | |
| 37. NAME OF WITNESS | | 38. NAME OF WITNESS | |
| 39. NAME OF WITNESS | | 40. NAME OF WITNESS | |
| 41. NAME OF WITNESS | | 42. NAME OF WITNESS | |
| 43. NAME OF WITNESS | | 44. NAME OF WITNESS | |
| 45. NAME OF WITNESS | | 46. NAME OF WITNESS | |
| 47. NAME OF WITNESS | | 48. NAME OF WITNESS | |
| 49. NAME OF WITNESS | | 50. NAME OF WITNESS | |
| 51. NAME OF WITNESS | | 52. NAME OF WITNESS | |
| 53. NAME OF WITNESS | | 54. NAME OF WITNESS | |
| 55. NAME OF WITNESS | | 56. NAME OF WITNESS | |
| 57. NAME OF WITNESS | | 58. NAME OF WITNESS | |
| 59. NAME OF WITNESS | | 60. NAME OF WITNESS | |
| 61. NAME OF WITNESS | | 62. NAME OF WITNESS | |
| 63. NAME OF WITNESS | | 64. NAME OF WITNESS | |
| 65. NAME OF WITNESS | | 66. NAME OF WITNESS | |
| 67. NAME OF WITNESS | | 68. NAME OF WITNESS | |
| 69. NAME OF WITNESS | | 70. NAME OF WITNESS | |
| 71. NAME OF WITNESS | | 72. NAME OF WITNESS | |
| 73. NAME OF WITNESS | | 74. NAME OF WITNESS | |
| 75. NAME OF WITNESS | | 76. NAME OF WITNESS | |
| 77. NAME OF WITNESS | | 78. NAME OF WITNESS | |
| 79. NAME OF WITNESS | | 80. NAME OF WITNESS | |
| 81. NAME OF WITNESS | | 82. NAME OF WITNESS | |
| 83. NAME OF WITNESS | | 84. NAME OF WITNESS | |
| 85. NAME OF WITNESS | | 86. NAME OF WITNESS | |
| 87. NAME OF WITNESS | | 88. NAME OF WITNESS | |
| 89. NAME OF WITNESS | | 90. NAME OF WITNESS | |
| 91. NAME OF WITNESS | | 92. NAME OF WITNESS | |
| 93. NAME OF WITNESS | | 94. NAME OF WITNESS | |
| 95. NAME OF WITNESS | | 96. NAME OF WITNESS | |
| 97. NAME OF WITNESS | | 98. NAME OF WITNESS | |
| 99. NAME OF WITNESS | | 100. NAME OF WITNESS | |

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| 03676 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 03671 | | | | | |
|---|--|------------------|--|---|--|---|--|---|-------------------------------------|---|--|---|--|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | | First
GEORGE | | | Middle
C. | | | Last
WESSON | | | 2a. DATE KNOWN
OF ESTI-
DEATH MATED <input checked="" type="checkbox"/> Month Day Year 19 | | 2b. HOUR
M | |
| 3. SEX
male | | 4. RACE
negro | | 5. DATE OF BIRTH | | 6. AGE (In years
last birthday)
57 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN | | 2c. DATE PRONOUNCED DEAD
Month Day Year 1969 | | 2d. HOUR
P. M. | |
| 7a. BIRTHPLACE (State or foreign
country)
N. C. | | | 7b. CITIZEN OF WHAT COUNTRY?
7189. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Baltimore Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH
Towson | | | | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital
give street address)
Greater Balto Med Center | | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
Maryland | | | | 13b. COUNTY
— | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
1541 Broadway | | | | | |
| 14. FATHER'S NAME
First Middle Last
Joseph WESSON | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
ASIA MARIE PARKER | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
No | | | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service)
239-12-451 | | 17. INFORMANT
ADDRESS
CORA WESSON 3031 BELVEDERE AVE | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u>
<u>4124</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. } (b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION
WAS PERFORMED? | | | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY (At home, farm, street,
factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion
death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | |
| ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type) | | | | Werner U. Spitz, M.D. | | | | | | | | 22b. DATE SIGNED
3/25/69 | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
BURIAL | | | | 23b. DATE
3/29/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Calvary | | | | 23d. LOCATION (City or Town) (County) (State)
Q. D. County Md. | | | | | |
| 24. FUNERAL DIRECTOR
Joseph B. Locks | | | | ADDRESS
1304 N. Central Ave | | | | 25a. REC'D BY REGISTRAR
DATE MAR 27 1969 | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03677

CERTIFICATE OF DEATH

03672

| | | | | | | | | |
|--|------------------------------|--|--|---|---|--|----------|--|
| 1. DECEASED-NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH | | 2b. HOUR | |
| CHARLOTTE | | JANE | | WEST | March 28 1969 | | 10:45 P | |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| Female | White | | 5-3-1899 1892 | | 76 YRS. | MONTHS DAYS | | HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Maryland | USA | | | | Baltimore Md. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Towson | | St. Joseph's Hospital | | Homemaker | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER | | |
| Maryland | | — ✓ | | Baltimore | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 4506 Dunland Road | | |
| 14. FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | First | Middle Last |
| Wm. H. Robertson | | | | | ,, Margaret J. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | |
| no | | | | | | Mr. William West, 8905 Old Frederick Road | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Acute pyelonephritis with uremia</u> | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | |
| (b) <u>Cerebral thrombosis</u> | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| (c) | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | | | |
| While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that he (this hospital) attended the deceased from <u>3-25</u> , 19 <u>69</u> , to <u>3-28</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3-28</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE | | | | | | 22c. DATE SIGNED | | |
| <u>J. Banderas M.D.</u> | | | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 3-28-69 |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS | | | | |
| Julio Banderas, M.D. | | | | 7620 York Rd., Towson, Md. | | 21204 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | 4/1/69 | | Baltimore National Cemetery | | Balto., Md. | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | 25a. RECEIVED BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE |
| Witzke, 4101 Edmondson Ave., 21229 | | | | | | APR 1 1969 | | <u>Julio Banderas</u> |

RECEIVED

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

03678

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03673

| | | | | | | | | | |
|--|-----------------|-------|--|--------------------------|--|---|--|--|--|
| 1. DECEASED-NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH | | 2b. HOUR | | |
| Mary | | A. | | White | Month 3 Day 18 Year 69 | | 4:15 A.M. | | |
| 3. SEX | female | | 4. RACE | white | | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | | |
| | | | | | Jan. 27, 1881 | | 88 YRS. | | |
| 7a. BIRTHPLACE (State or foreign country) | Md. | | 7b. CITIZEN OF WHAT COUNTRY? | U. S. | | 8. MARRIED | 9. COUNTY OF DEATH | | |
| | | | | | WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | Baltimore | | |
| 10. CITY OR TOWN OF DEATH | Catonsville | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | SPRING GROVE STATE HOSP. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| | | | | | housewife | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | Md. | | 13b. COUNTY | Balto. | | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | | |
| | | | | | Catonsville | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME | First | | Middle | Last | 15. MOTHER'S MAIDEN NAME | | First | | |
| | Henry S. Miller | | | | Fannie Owens | | Middle | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | 212-05-6347D | | 17. INFORMANT | | | |
| | | | | | Records: SPRING GROVE STATE HOSPITAL | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Bilateral Pneumonia</u> | | | | | | days | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (b) <u>ASHD & heart failure</u> | | | | | | years | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) <u>Generalized AS</u> | | | | | | years | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | HOUR A.M. Month Day Year | | | | | | |
| (If either, notify medical examiner) | | | P.M. 19 | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION | | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> | | | | | | Street or R.F.D. No. City or Town County State | | | |
| of work <input type="checkbox"/> of work <input type="checkbox"/> | | | | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Feb. 11, 1969</u> , to <u>March 18, 1969</u> , that (I) (we) last saw the deceased alive on <u>March 18, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | ATTENDING PHYS. | |
| | | | | | | <input type="checkbox"/> | | <input type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | 22c. DATE SIGNED | |
| ALBERTO M. GUTIERREZ, M.D. | | | | | | SPRING GROVE STATE HOSPITAL | | 3-18-69 | |
| Baltimore, Maryland 21228 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | | 3/21/69 | | Loudon Park | | Baltimore, Md. | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| 6212 Balto Nat Pike Wm Cook-Brooks West Inc Balt Md. 21228 | | | | | | MAR 21 1969 | | | |

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03679

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03674

| | | | | | | | | | | | |
|---|-------------------------|--|---|---|---|--|---|---|--|---|----------------------------|
| 1. DECEASED-NAME
(Type or Print) WILLIAM R. WHITEFORD | | | First Middle Last | | | 2a. DATE KNOWN OF ESTI-
DEATH MATED <input checked="" type="checkbox"/> March 4, 1969 | | | 2b. HOUR 12:10 M. | | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
June 6, 1898 | 6. AGE (In years last birthday)
70 YRS. | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
Month March 4, Day Year 1969 | | | 2d. HOUR
1:00 M. |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore | | | | | |
| 10. CITY OR TOWN OF DEATH
Essex 21221 | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
1640 Howard Avenue | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Mechanic | | | 12b. KIND OF BUSINESS OR INDUSTRY
Ref-AirCondition | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN
Essex | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
1640 Howard Avenue | | |
| 14. FATHER'S NAME
Nicholas Frank Whiteford | | | | 15. MOTHER'S MAIDEN NAME
Louisa Einwhacter | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) No | | | 16b. SOCIAL SECURITY NO.
217 09 5160 | | 17. INFORMANT
John E. Whiteford | | | 17. ADDRESS
209 Vernon Ave Glen Burnie | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Coronary Occlusion
4109
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) HCVD
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE
Theodore C. Patterson | | EXAMINER'S NAME (Type)
Theodore C. Patterson, M.D. | | 3427 Dundalk Ave. Dundalk, Md. 21222 | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
3/7/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore Co., Md. | | 25a. REC'D BY REGISTRAR
DATE MAR 7 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |
| 24. FUNERAL DIRECTOR
James E. Bruzdinski | | ADDRESS
1407 Eastern Ave. | | | | | | | | | |

038879

MEDICAL EXAMINER'S REPORT OF CASE

REPORT OF VITAL RECORDS

ATTESTED

DATE

TIME

PLACE

BY

DATE

NAME

ADDRESS

CITY

STATE

LOCALITY

DATE

Handwritten signature and text, possibly "H. J. ..."

Handwritten mark, possibly "X"

Handwritten marks, possibly "X" and "J"

Handwritten signature

THEODORE J. ...

DATE

TIME

PLACE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|--|--|---|--|--|---|
| 03680 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | 03675 | |
| Item #11, Film G410 3/24/69 km | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED-NAME
(Type or print) | | | 2a. DATE OF DEATH | 2b. HOUR | |
| First Middle Last
Susie E. Biscoe Wible | | | Month Day Year
March 16, 1969 | M | |
| 3. SEX | | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS DAYS |
| Female | | White | March 19, 1893 | 75 YRS. | IF UNDER 24 HRS. HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH | |
| Maryland | | USA | | Baltimore Md. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | |
| Arbutus | | 1157 Circle Drive | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER |
| Maryland | | Baltimore | Arbutus | | 1157 Circle Drive |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | |
| First Middle Last
William Lee Biscoe | | First Middle Last
Mary Amelia Biscoe | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address | | |
| | | 215-07-3246D | Langley Biscoe 1147 Circle Drive, Baltimore, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>undifferentiated carcinoma of rectum</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<u>Hypertensive Cardiovascular Dis</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| 2-12-69 | | mass in rt neck | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>April 5</u> , 19 <u>66</u> , to <u>March 16</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>March 15</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| <u>Earl Pass M.D.</u> | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 3-16-69 | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | |
| Earl Pass M. D. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) |
| Burial | | 3/19/69 | Ebenezer Cemetery | | Great Mills, St. Mary's, Maryland |
| 24. FUNERAL DIRECTOR | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE |
| W. Clarke Mattingley Leonardtown, Maryland | | | MAR 19 1969 | | <u>Charles Judge</u> |

03880

03880

NAME: [illegible] TITLE: [illegible]

DATE: [illegible] TIME: [illegible]

LOCATION: [illegible]

REMARKS: [illegible]

TIME: [illegible]

REMARKS: [illegible]

DATE: [illegible]

TIME: [illegible]

REMARKS: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2 and 3 and return them to the funeral director. This certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

03681

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03676

| | | | | | |
|--|--|---|--|--|--|
| 1. DECEASED-NAME
(Type or print) First Middle Last
Clarence Mitchell Widerman | | | 2a. DATE OF DEATH
Month Day Year
MARCH 30, 1969 11:55 AM | | 2b. HOUR |
| 3. SEX
Male | 4. RACE
Caucasian | 5. DATE OF BIRTH
10/5/94 | | 6. AGE (In years last birthday)
74 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH
Baltimore County Md. | | |
| 10. CITY OR TOWN OF DEATH
Randallstown | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Balto. Co. Gen. Hosp. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
RETIRED | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | 13b. COUNTY
Balto. | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER
6500 Gilmore St. |
| 14. FATHER'S NAME First Middle Last
Edward Widerman | | 15. MOTHER'S MAIDEN NAME First Middle Last
Sarah Ritter | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | 16b. SOCIAL SECURITY NO.
213-03-5496 | | 17. INFORMANT Address
B. Seibert, Balto. Co. Gen. Hosp. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 531.1 Generalized peritonitis
DUE TO, OR AS A CONSEQUENCE OF (b) Perforation of gastric ulcer
DUE TO, OR AS A CONSEQUENCE OF (c) Perforated gastric ulcer - Duodenal ulcer
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
HRS-DAYS MONTHS - | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Bronchopneumonia | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-28, 1969, to 3-30, 1969, that (I) (we) last saw the deceased alive on 3-30, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Samuel Calle, MD | | 22c. DATE SIGNED
3/30/69 | | 22d. PHYSICIAN'S NAME (Type)
22e. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
4-2-69 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Olive | |
| 23d. LOCATION (City or Town) (County) (State)
Randallstown Balto. Md. | | 23e. REC'D BY REGISTRAR
23f. REGISTRAR'S SIGNATURE
John T. Stansbury, Sr. 6411 Windsor Mill Rd. | | | |
| DATE APR 3 1969 | | | | | |

General and specific

Information of genetic value

Genetic value - General value

Branching structure

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Genetic value - General value

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | |
|--|--|--|--|---|----------------------|---|---------------------------------|--|---|--|------------------|----------------------------|--|--|
| 03682 | | | | | CERTIFICATE OF DEATH | | | | | 03677 | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH | | | 2b. HOUR | | | | | |
| ALICE | | | G. | | WIELAND | March 7, 1969 | | | 9:08 P.M. | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| Female | | White | | 10-5-1891 | | | 77 YRS. | | MONTHS | | DAYS | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | Md. | | | | |
| Maryland | | U.S.A. | | | | | Baltimore | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Arbutus | | | 5524 Carville Avenue | | | Housewife | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| Maryland | | | Baltimore | | | Arbutus | | | 5524 Carville Avenue | | | | | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First | Middle | Last | | | |
| Llewellyn | | | Hudgins | | | Gertrude | | | Funk | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | | | | |
| | | | 213-10-0401 | | | Mrs. Doris M. Daniel, | | | 169 Oaklee Village | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>471X</u> <u>apoplexy & left Hemiplegia</u> | | | | | | | | | | 4 day | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>confluent Broncho. pneumonia</u> | | | | | | | | | | 10 day | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Cardio-Vascular Disease</u> | | | | | | | | | | 5 yrs | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | |
| <u>Cerebral Depression</u> | | | | | | | | | | 3 yrs | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | |
| | | HOUR A.M. Month Day Year | | | | | | | | | | | | |
| | | P.M. 19 | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | | Street or R.F.D. No. | | City or Town | | County State | | | |
| | | | | | | | | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>2</u> , 19 <u>60</u> , to <u>March 7, 1969</u> , that (1) (we) last saw the deceased alive on <u>3/7/1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Bruce Brumbaugh MD</u> | | | | | | | | | | 22c. DATE SIGNED | | | | |
| 22d. PHYSICIAN'S NAME (Type) Dr. Bruce Brumbaugh | | | | | | | | | | 3/8/69 | | | | |
| 22e. ADDRESS | | | | | | | | | | | | | | |
| 5609 Main Street, Elkridge, Maryland | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) | | (County) | | (State) | | | |
| BURIAL | | 3-11-1969 | | Loudon Park Cemetery | | | Baltimore, Maryland | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| ADDRESS | | | | | | | | | | DATE | | | | |
| Howard H. Hubbard, 4107 Wilkens Ave. 21229 | | | | | | | | | | MAR 12 1969 | | Charles Yundt | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03683

CERTIFICATE OF DEATH

03678

| | | | | | | | | | |
|--|--|--|--|---|---|--|--|---|-----|
| 1. DECEASED-NAME
(Type or print) JOHN H. WILSON | | | 2a. DATE OF DEATH
March 1, 1969 | | | 2b. HOUR
1:35 PM | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
June 9, 1898 | | 6. AGE (In years last birthday)
70 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
New Jersey | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore | | | Md. |
| 10. CITY OR TOWN OF DEATH
Catonsville | | 11. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital give street address)
14 Sanford Avenue | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Retired | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Catonsville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
14 Sanford Avenue 21228 | |
| 14. FATHER'S NAME
Unknown | | | 15. MOTHER'S MAIDEN NAME
Catherine Redhing | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
No | | 16b. SOCIAL SECURITY NO.
705-05-0947 | | 17. INFORMANT
Mrs. Eloise Wilson, 14 Sanford Ave. 21228 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of stomach with
1519 DUE TO, OR AS A CONSEQUENCE OF abd. metastases
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4-5 months | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If injured, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION
Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-19-68 , 19 68 , to March 1 , 19 69 , that (I) (we) last saw the deceased alive on Feb 28 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
John A. Nesbitt, Jr. | | | | | DEGREE
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
3-3-69 | | |
| 22d. PHYSICIAN'S NAME (Type)
Dr. John A. Nesbitt, Jr. | | | | | 22e. ADDRESS
1009 Frederick Road, Balto., Md. 21228 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
3-5-1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Moreland Memorial Park | | | 23d. LOCATION (City or Town) (County) (State) Md.
2901 Taylor Ave., Balto. Co. | | |
| 24. FUNERAL DIRECTOR
Howard H. Hubbard, 4107 Wilkens Ave. 21229 | | | | | 25a. REC'D BY REGISTRAR
DATE MAR 5 1969 | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judar | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|--|--|---|--|--|---|---|---|-----------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First | Middle | Lost | 2a. DATE OF DEATH | | 2b. HOUR | | |
| Joseph Windsor | | | R. | | | March 6, 1969 | | 9:45 a. M. | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years lost birthday) | | 7. IF UNDER 1 YEAR | | |
| male | | white | | April 23, 1901 | | 67 YRS | | MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| N. C. | | U. S. | | | | Baltimore Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Catonsville | | | SPRING GROVE STATE HOSP. | | | seaman | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | |
| Md. | | | 13 | | Balto. | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 3210 Windsor Avenue | |
| 14. FATHER'S NAME | | | First | Middle | Lost | 15. MOTHER'S MAIDEN NAME | | | | |
| T. R. Windsor | | | | | | Mc Laine Windsor | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | | |
| | | | 154-10-8467 | | | Records: SPRING GROVE STATE HOSPITAL | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease with myocardial infarction or pulmonary embolus | | | | | | | | | | |
| 4109 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (b) Cerebrovascular accident | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (c) Bronchopneumonia; by history | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| Aspiration pneumonia; by history: Severe Decubitus ulcers. | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| | | HOUR A.M. Month Day Year | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | | | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from Jan. 26, 1961, to March 6, 1969, that (I) (we) last saw the deceased alive on March 6, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | | | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | |
| | | | | | | | | | 3-6-69 | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | 22e. ADDRESS | | | | | |
| Rafael H. Marin, M.D. | | | | | SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| BURIAL | | 3/14/69 | | St. Johns Cem. | | Ellicott City Howard Md | | | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
| E. S. Mac Nabb | | 301 Franklin Rd Balto 28 Md | | MAR 18 1969 | | | | | | |

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 1-69

| 03685 | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 03680 | | | |
|--|--|--|--|--|-------------------|---|---|--|-----------------------------------|----------------------------|--|
| 1. DECEASED-NAME
(Type or print) | | | | First | Middle | Last | 2a. DATE OF DEATH | | | 2b. HOUR | |
| Edward | | | | NMN | | Woodall | Month | Day | Year | M | |
| March | | | | 21 | | 69 | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | |
| Male | | White | | June 2, 1880 | | | 88 84 YRS. | | MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Balto. Md. | | USA | | | | Baltimore Md. | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Randallstown | | | BCGH | | | Clerk | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | |
| Md. | | | Balto. | | Balto. | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 728 Milford Mill Rd. | | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First | Middle | Last |
| William | | | E. | | Woodall | Mary | | | E. | | Hooper |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT Address | | | | | |
| no | | | 212-07-9968 | | | Lutherville | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Acute G.I. bleeding + shock</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| <u>Generalized Arteriosclerosis - Severe Chronic Brain Sy.</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town | | County State | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-25-1969</u> , to <u>3-21-1969</u> , that (I) (we) last saw the deceased alive on <u>3-21-1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | ATTENDING PHYS. | | 22c. DATE SIGNED | |
| <u>Cesar Valle Cervero</u> | | | | | | | | <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. | | <u>3-21-69</u> | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | | | |
| Dr. Cesar Valle Cervero | | | | | | 8629 Liberty Rd. Randallstown, Md 21133 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 3/24/1969 | | Mt. Olivet Cemetery | | | | Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR | | | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Eugenia F. Seitz 5209 York Rd. Balto. Md. | | | | | | | | MAR 24 1969 | | <u>Charles Judge</u> | |
| Seitz Funeral Home 21212 | | | | | | | | | | | |

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CRIMINALS OF NAME

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 1-68

03686

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03681

CERTIFICATE OF DEATH

| | | | | | | | |
|--|--|---|---|---|--|---|--|
| 1. DECEASED-NAME
(Type or print) <i>Marcia C. Normser</i> | | | 2a. DATE OF DEATH
Month <i>March</i> Day <i>4</i> Year <i>1969</i> | | | 2b. HOUR
<i>6:30</i> M | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
<i>Jan 16, 1921</i> | | 6. AGE (In years last birthday)
<i>48</i> YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
<i>Kentucky</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Baltimore</i> Md. | |
| 10. CITY OR TOWN OF DEATH
<i>Pikesville</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>3424 Birch Hollow Rd</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>Teacher</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>City School</i> | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>Maryland</i> | | 13b. COUNTY
<i>Baltimore</i> | | 13c. CITY OR TOWN
<i>Pikesville</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET AND NUMBER
<i>3424 Birch Hollow Rd</i> | | 14. FATHER'S NAME
First <i>Julius</i> Middle <i>Chesley</i> Last <i>Normser</i> | | 15. MOTHER'S MAIDEN NAME
First <i>Rose</i> Middle <i>?</i> Last <i>Normser</i> | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> (If yes give war or dates of service) | |
| 16a. SOCIAL SECURITY NO.
<i>271-16-5269</i> | | 17. INFORMANT
<i>Sylvan Normser</i> | | 18. ADDRESS
<i>3424 Birch Hollow Rd</i> | | 19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>5 yrs</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Metastatic Carcinoma</i>
<i>174X</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <i>Carcinoma of the breast</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>2/1</i> , 19 <i>68</i> , to <i>3/3</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>3/3</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Milton Schleusoff MD</i> | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<i>3/4/69</i> | |
| 22d. PHYSICIAN'S NAME (Type)
<i>Milton Schleusoff MD</i> | | 22e. ADDRESS
<i>6410 Windsor Mill Rd</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 23b. DATE
<i>March 6 1969</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Ches Shalom</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Baltimore, Md</i> | |
| 24. FUNERAL DIRECTOR
<i>Sol Leunson</i> | | ADDRESS
<i>2nd - 6010 Reisterstown Rd</i> | | 25a. REC'D BY REGISTRAR
<i>Charles Judge</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |
| DATE
<i>MAR 10 1969</i> | | | | | | | |

02350

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03687

CERTIFICATE OF DEATH

03682

| | | | | | | | | | | | |
|---|--|------------------------------|--|--|------------------------------------|---|---|--|-----------------------------------|--|------|
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Lost | 2a. DATE OF DEATH
Month Day Year | | | 2b. HOUR | | |
| ERNEST WEYDAN WRIGHT | | | | | | 3 3 1969 | | | 3:50p M | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| Male | | Caucasian | | 5-12-1911 | | 57 YRS. | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Scotland | | U.S.A. | | | | Baltimore Md. | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Towson, Md. | | | Greater Balto. Med. Center | | | Vice Pres. Railroad | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| Md. | | | Baltimore | | Towson | | | Margarette Ave., 1310 | | | |
| 14. FATHER'S NAME | | | First | Middle | Lost | 15. MOTHER'S MAIDEN NAME | | | First | Middle | Lost |
| Ernest B. Wright | | | | | | Mary Diack | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | |
| No | | | 478-01-4991 | | | Virginia B. Wright | | | Same as 13e | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Pelvic and right leg cellulitis</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| (b) <u>Carcinoma of urinary bladder with liver metastases</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/20</u> , 19 <u>69</u> , to <u>3/3</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3/3</u> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | 22e. ADDRESS | | | 3/4/69 | | | | | |
| Rudiger Breitenecker, M. D. | | | Greater Baltimore Medical Center | | | | | | | | |
| 23a. BURIAL-CREATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| XXXXXX | | | 3/6/69 | | Green Mount | | Baltimore Md. | | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | | | 25a. REC'D BY REGISTRAR DATE | | 25b. REGISTRAR'S SIGNATURE | | | |
| Wm. Cook-Brooks Towson, 1050 York Road | | | | | | MAR 5 1969 | | K. Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| <div style="display: flex; justify-content: space-between;"> 03688 MARYLAND STATE DEPARTMENT OF HEALTH 03683 </div> <div style="display: flex; justify-content: space-between;"> DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH </div> | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) HOWARD H. WRIGHT SR. | | | | | | 2a. DATE OF DEATH March 9, 1969 | | | 2b. HOUR 1968 | | |
| 3. SEX Male | | 4. RACE Caucasian | | 5. DATE OF BIRTH Nov. 11, 1910 | | 6. AGE (In years last birthday) 58 YRS. | | IF UNDER 1 YEAR MONTHS | | IF UNDER 24 HRS. HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore | | | Md. | | |
| 10. CITY OR TOWN OF DEATH Towson | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) DOA St. Joseph's Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Salesman | | | 12b. KIND OF BUSINESS OR INDUSTRY Paint | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Lutherville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER 1505 Melton Road | | | |
| 14. FATHER'S NAME First Middle Last Robert Hartman Wright | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Anna Kearney | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16b. SOCIAL SECURITY NO. 213-16-6705 | | 17. INFORMANT Mrs. Virginia Wright | | | | Address Same as # 13 E | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
402x IMMEDIATE CAUSE (a) Cardiac Arrest
DUE TO, OR AS A CONSEQUENCE OF Hypertension
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF _____
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan, 1968 to July, 1968 that (I) (we) last saw the deceased alive on July 18, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Keith A. Manley | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 3-10-69 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Keith A. Manley | | | | 22e. ADDRESS 2045 York Road | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 3-12-69 | | 23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery | | | | 23d. LOCATION (City or Town) Pikesville (County) (State) Reisterstown Maryland | | | |
| 24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Inc. Towson, Md. | | | | ADDRESS | | 25a. REC'D BY REGISTRAR MAR 11 1969 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

03022

03022

AMERICAN UNIVERSITY
WASHINGTON, D.C. 20004

| | | | | |
|---------|------------------|---------------|------|----------|
| STUDENT | NAME | DATE | TIME | PLACE |
| 1 | John Doe | Nov. 11, 1910 | 8:00 | Room 101 |
| 2 | Jane Smith | Nov. 11, 1910 | 8:15 | Room 101 |
| 3 | Robert Johnson | Nov. 11, 1910 | 8:30 | Room 101 |
| 4 | William Brown | Nov. 11, 1910 | 8:45 | Room 101 |
| 5 | Elizabeth Taylor | Nov. 11, 1910 | 9:00 | Room 101 |

NO. 101-102-103-104-105-106-107-108-109-110-111-112-113-114-115-116-117-118-119-120-121-122-123-124-125-126-127-128-129-130-131-132-133-134-135-136-137-138-139-140-141-142-143-144-145-146-147-148-149-150-151-152-153-154-155-156-157-158-159-160-161-162-163-164-165-166-167-168-169-170-171-172-173-174-175-176-177-178-179-180-181-182-183-184-185-186-187-188-189-190-191-192-193-194-195-196-197-198-199-200-201-202-203-204-205-206-207-208-209-210-211-212-213-214-215-216-217-218-219-220-221-222-223-224-225-226-227-228-229-230-231-232-233-234-235-236-237-238-239-240-241-242-243-244-245-246-247-248-249-250-251-252-253-254-255-256-257-258-259-260-261-262-263-264-265-266-267-268-269-270-271-272-273-274-275-276-277-278-279-280-281-282-283-284-285-286-287-288-289-290-291-292-293-294-295-296-297-298-299-300-301-302-303-304-305-306-307-308-309-310-311-312-313-314-315-316-317-318-319-320-321-322-323-324-325-326-327-328-329-330-331-332-333-334-335-336-337-338-339-340-341-342-343-344-345-346-347-348-349-350-351-352-353-354-355-356-357-358-359-360-361-362-363-364-365-366-367-368-369-370-371-372-373-374-375-376-377-378-379-380-381-382-383-384-385-386-387-388-389-390-391-392-393-394-395-396-397-398-399-400-401-402-403-404-405-406-407-408-409-410-411-412-413-414-415-416-417-418-419-420-421-422-423-424-425-426-427-428-429-430-431-432-433-434-435-436-437-438-439-440-441-442-443-444-445-446-447-448-449-450-451-452-453-454-455-456-457-458-459-460-461-462-463-464-465-466-467-468-469-470-471-472-473-474-475-476-477-478-479-480-481-482-483-484-485-486-487-488-489-490-491-492-493-494-495-496-497-498-499-500-501-502-503-504-505-506-507-508-509-510-511-512-513-514-515-516-517-518-519-520-521-522-523-524-525-526-527-528-529-530-531-532-533-534-535-536-537-538-539-540-541-542-543-544-545-546-547-548-549-550-551-552-553-554-555-556-557-558-559-560-561-562-563-564-565-566-567-568-569-570-571-572-573-574-575-576-577-578-579-580-581-582-583-584-585-586-587-588-589-590-591-592-593-594-595-596-597-598-599-600-601-602-603-604-605-606-607-608-609-610-611-612-613-614-615-616-617-618-619-620-621-622-623-624-625-626-627-628-629-630-631-632-633-634-635-636-637-638-639-640-641-642-643-644-645-646-647-648-649-650-651-652-653-654-655-656-657-658-659-660-661-662-663-664-665-666-667-668-669-670-671-672-673-674-675-676-677-678-679-680-681-682-683-684-685-686-687-688-689-690-691-692-693-694-695-696-697-698-699-700-701-702-703-704-705-706-707-708-709-710-711-712-713-714-715-716-717-718-719-720-721-722-723-724-725-726-727-728-729-730-731-732-733-734-735-736-737-738-739-740-741-742-743-744-745-746-747-748-749-750-751-752-753-754-755-756-757-758-759-760-761-762-763-764-765-766-767-768-769-770-771-772-773-774-775-776-777-778-779-780-781-782-783-784-785-786-787-788-789-790-791-792-793-794-795-796-797-798-799-800-801-802-803-804-805-806-807-808-809-810-811-812-813-814-815-816-817-818-819-820-821-822-823-824-825-826-827-828-829-830-831-832-833-834-835-836-837-838-839-840-841-842-843-844-845-846-847-848-849-850-851-852-853-854-855-856-857-858-859-860-861-862-863-864-865-866-867-868-869-870-871-872-873-874-875-876-877-878-879-880-881-882-883-884-885-886-887-888-889-890-891-892-893-894-895-896-897-898-899-900-901-902-903-904-905-906-907-908-909-910-911-912-913-914-915-916-917-918-919-920-921-922-923-924-925-926-927-928-929-930-931-932-933-934-935-936-937-938-939-940-941-942-943-944-945-946-947-948-949-950-951-952-953-954-955-956-957-958-959-960-961-962-963-964-965-966-967-968-969-970-971-972-973-974-975-976-977-978-979-980-981-982-983-984-985-986-987-988-989-990-991-992-993-994-995-996-997-998-999-1000-1001-1002-1003-1004-1005-1006-1007-1008-1009-1010-1011-1012-1013-1014-1015-1016-1017-1018-1019-1020-1021-1022-1023-1024-1025-1026-1027-1028-1029-1030-1031-1032-1033-1034-1035-1036-1037-1038-1039-1040-1041-1042-1043-1044-1045-1046-1047-1048-1049-1050-1051-1052-1053-1054-1055-1056-1057-1058-1059-1060-1061-1062-1063-1064-1065-1066-1067-1068-1069-1070-1071-1072-1073-1074-1075-1076-1077-1078-1079-1080-1081-1082-1083-1084-1085-1086-1087-1088-1089-1090-1091-1092-1093-1094-1095-1096-1097-1098-1099-1100-1101-1102-1103-1104-1105-1106-1107-1108-1109-1110-1111-1112-1113-1114-1115-1116-1117-1118-1119-1120-1121-1122-1123-1124-1125-1126-1127-1128-1129-1130-1131-1132-1133-1134-1135-1136-1137-1138-1139-1140-1141-1142-1143-1144-1145-1146-1147-1148-1149-1150-1151-1152-1153-1154-1155-1156-1157-1158-1159-1160-1161-1162-1163-1164-1165-1166-1167-1168-1169-1170-1171-1172-1173-1174-1175-1176-1177-1178-1179-1180-1181-1182-1183-1184-1185-1186-1187-1188-1189-1190-1191-1192-1193-1194-1195-1196-1197-1198-1199-1200-1201-1202-1203-1204-1205-1206-1207-1208-1209-1210-1211-1212-1213-1214-1215-1216-1217-1218-1219-1220-1221-1222-1223-1224-1225-1226-1227-1228-1229-1230-1231-1232-1233-1234-1235-1236-1237-1238-1239-1240-1241-1242-1243-1244-1245-1246-1247-1248-1249-1250-1251-1252-1253-1254-1255-1256-1257-1258-1259-1260-1261-1262-1263-1264-1265-1266-1267-1268-1269-1270-1271-1272-1273-1274-1275-1276-1277-1278-1279-1280-1281-1282-1283-1284-1285-1286-1287-1288-1289-1290-1291-1292-1293-1294-1295-1296-1297-1298-1299-1300-1301-1302-1303-1304-1305-1306-1307-1308-1309-1310-1311-1312-1313-1314-1315-1316-1317-1318-1319-1320-1321-1322-1323-1324-1325-1326-1327-1328-1329-1330-1331-1332-1333-1334-1335-1336-1337-1338-1339-1340-1341-1342-1343-1344-1345-1346-1347-1348-1349-1350-1351-1352-1353-1354-1355-1356-1357-1358-1359-1360-1361-1362-1363-1364-1365-1366-1367-1368-1369-1370-1371-1372-1373-1374-1375-1376-1377-1378-1379-1380-1381-1382-1383-1384-1385-1386-1387-1388-1389-1390-1391-1392-1393-1394-1395-1396-1397-1398-1399-1400-1401-1402-1403-1404-1405-1406-1407-1408-1409-1410-1411-1412-1413-1414-1415-1416-1417-1418-1419-1420-1421-1422-1423-1424-1425-1426-1427-1428-1429-1430-1431-1432-1433-1434-1435-1436-1437-1438-1439-1440-1441-1442-1443-1444-1445-1446-1447-1448-1449-1450-1451-1452-1453-1454-1455-1456-1457-1458-1459-1460-1461-1462-1463-1464-1465-1466-1467-1468-1469-1470-1471-1472-1473-1474-1475-1476-1477-1478-1479-1480-1481-1482-1483-1484-1485-1486-1487-1488-1489-1490-1491-1492-1493-1494-1495-1496-1497-1498-1499-1500-1501-1502-1503-1504-1505-1506-1507-1508-1509-1510-1511-1512-1513-1514-1515-1516-1517-1518-1519-1520-1521-1522-1523-1524-1525-1526-1527-1528-1529-1530-1531-1532-1533-1534-1535-1536-1537-1538-1539-1540-1541-1542-1543-1544-1545-1546-1547-1548-1549-1550-1551-1552-1553-1554-1555-1556-1557-1558-1559-1560-1561-1562-1563-1564-1565-1566-1567-1568-1569-1570-1571-1572-1573-1574-1575-1576-1577-1578-1579-1580-1581-1582-1583-1584-1585-1586-1587-1588-1589-1590-1591-1592-1593-1594-1595-1596-1597-1598-1599-1600-1601-1602-1603-1604-1605-1606-1607-1608-1609-1610-1611-1612-1613-1614-1615-1616-1617-1618-1619-1620-1621-1622-1623-1624-1625-1626-1627-1628-1629-1630-1631-1632-1633-1634-1635-1636-1637-1638-1639-1640-1641-1642-1643-1644-1645-1646-1647-1648-1649-1650-1651-1652-1653-1654-1655-1656-1657-1658-1659-1660-1661-1662-1663-1664-1665-1666-1667-1668-1669-1670-1671-1672-1673-1674-1675-1676-1677-1678-1679-1680-1681-1682-1683-1684-1685-1686-1687-1688-1689-1690-1691-1692-1693-1694-1695-1696-1697-1698-1699-1700-1701-1702-1703-1704-1705-1706-1707-1708-1709-1710-1711-1712-1713-1714-1715-1716-1717-1718-1719-1720-1721-1722-1723-1724-1725-1726-1727-1728-1729-1730-1731-1732-1733-1734-1735-1736-1737-1738-1739-1740-1741-1742-1743-1744-1745-1746-1747-1748-1749-1750-1751-1752-1753-1754-1755-1756-1757-1758-1759-1760-1761-1762-1763-1764-1765-1766-1767-1768-1769-1770-1771-1772-1773-1774-1775-1776-1777-1778-1779-1780-1781-1782-1783-1784-1785-1786-1787-1788-1789-1790-1791-1792-1793-1794-1795-1796-1797-1798-1799-1800-1801-1802-1803-1804-1805-1806-1807-1808-1809-1810-1811-1812-1813-1814-1815-1816-1817-1818-1819-1820-1821-1822-1823-1824-1825-1826-1827-1828-1829-1830-1831-1832-1833-1834-1835-1836-1837-1838-1839-1840-1841-1842-1843-1844-1845-1846-1847-1848-1849-1850-1851-1852-1853-1854-1855-1856-1857-1858-1859-1860-1861-1862-1863-1864-1865-1866-1867-1868-1869-1870-1871-1872-1873-1874-1875-1876-1877-1878-1879-1880-1881-1882-1883-1884-1885-1886-1887-1888-1889-1890-1891-1892-1893-1894-1895-1896-1897-1898-1899-1900-1901-1902-1903-1904-1905-1906-1907-1908-1909-1910-1911-1912-1913-1914-1915-1916-1917-1918-1919-1920-1921-1922-1923-1924-1925-1926-1927-1928-1929-1930-1931-1932-1933-1934-1935-1936-1937-1938-1939-1940-1941-1942-1943-1944-1945-1946-1947-1948-1949-1950-1951-1952-1953-1954-1955-1956-1957-1958-1959-1960-1961-1962-1963-1964-1965-1966-1967-1968-1969-1970-1971-1972-1973-1974-1975-1976-1977-1978-1979-1980-1981-1982-1983-1984-1985-1986-1987-1988-1989-1990-1991-1992-1993-1994-1995-1996-1997-1998-1999-2000-2001-2002-2003-2004-2005-2006-2007-2008-2009-2010-2011-2012-2013-2014-2015-2016-2017-2018-2019-2020-2021-2022-2023-2024-2025-2026-2027-2028-2029-2030-2031-2032-2033-2034-2035-2036-2037-2038-2039-2040-2041-2042-2043-2044-2045-2046-2047-2048-2049-2050-2051-2052-2053-2054-2055-2056-2057-2058-2059-2060-2061-2062-2063-2064-2065-2066-2067-2068-2069-2070-2071-2072-2073-2074-2075-2076-2077-2078-2079-2080-2081-2082-2083-2084-2085-2086-2087-2088-2089-2090-2091-2092-2093-2094-2095-2096-2097-2098-2099-2100-2101-2102-2103-2104-2105-2106-2107-2108-2109-2110-2111-2112-2113-2114-2115-2116-2117-2118-2119-2120-2121-2122-2123-2124-2125-2126-2127-2128-2129-2130-2131-2132-2133-2134-2135-2136-2137-2138-2139-2140-2141-2142-2143-2144-2145-2146-2147-2148-2149-2150-2151-2152-2153-2154-2155-2156-2157-2158-2159-2160-2161-2162-2163-2164-2165-2166-2167-2168-2169-2170-2171-2172-2173-2174-2175-2176-2177-2178-2179-2180-2181-2182-2183-2184-2185-2186-2187-2188-2189-2190-2191-2192-2193-2194-2195-2196-2197-2198-2199-2200-2201-2202-2203-2204-2205-2206-2207-2208-2209-2210-2211-2212-2213-2214-2215-2216-2217-2218-2219-2220-2221-2222-2223-2224-2225-2226-2227-2228-2229-2230-2231-2232-2233-2234-2235-2236-2237-2238-2239-2240-2241-2242-2243-2244-2245-2246-2247-2248-2249-2250-2251-2252-2253-2254-2255-2256-2257-2258-2259-2260-2261-2262-2263-2264-2265-2266-2267-2268-2269-2270-2271-2272-2273-2274-2275-2276-2277-2278-2279-2280-2281-2282-2283-2284-2285-2286-2287-2288-2289-2290-2291-2292-2293-2294-2295-2296-2297-2298-2299-2300-2301-2302-2303-2304-2305-2306-2307-2308-2309-2310-2311-2312-2313-2314-2315-2316-2317-2318-2319-2320-2321-2322-2323-2324-2325-2326-2327-2328-2329-2330-2331-2332-2333-2334-2335-2336-2337-2338-2339-2340-2341-2342-2343-2344-2345-2346-2347-2348-2349-2350-2351-2352-2353-2354-2355-2356-2357-2358-2359-2360-2361-2362-2363-2364-2365-2366-2367-2368-2369-2370-2371-2372-2373-2374-2375-2376-2377-2378-2379-2380-2381-2382-2383-2384-2385-2386-2387-2388-2389-2390-2391-2392-2393-2394-2395-2396-2397-2398-2399-2400-2401-2402-2403-2404-2405-2406-2407-2408-2409-2410-2411-2412-2413-2414-2415-2416-2417-2418-2419-2420-2421-2422-2423-2424-2425-2426-2427-2428-2429-2430-2431-2432-2433-2434-2435-2436-2437-2438-2439-2440-2441-2442-2443-2444-2445-2446-2447-2448-2449-2450-2451-2452-2453-2454-2455-2456-2457-2458-2459-2460-2461-2462-2463-2464-2465-2466-2467-2468-2469-2470-2471-2472-2473-2474-2475-2476-2477-2478-2479-2480-2481-2482-2483-2484-2485-2486-2487-2488-2489-2490-2491-2492-2493-2494-2495-2496-2497-2498-2499-2500-2501-2502-2503-2504-2505-2506-2507-2508-2509-2510-2511-2512-2513-2514-2515-2516-2517-2518-2519-2520-2521-2522-2523-2524-2525-2526-2527-2528-2529-2530-2531-2532-2533-2534-2535-2536-2537-2538-2539-2540-2541-2542-2543-2544-2545-2546-2547-2548-2549-2550-2551-2552-2553-2554-2555-2556-2557-2558-2559-2560-2561-2562-2563-2564-2565-2566-2567-2568-2569-2570-2571-2572-2573-2574-2575-2576-2577-2578-2579-2580-2581-2582-2583-2584-2585-2586-2587-2588-2589-2590-2591-2592-2593-2594-2595-2596-2597-2598-2599-2600-2601-2602-2603-2604-2605-2606-2607-2608-2609-2610-2611-2612-2613-2614-2615-2616-2617-2618-2619-2620-2621-2622-2623-2624-2625-2626-2627-2628-2629-2630-2631-2632-2633-2634-2635-2636-2637-2638-2639-2640-2641-2642-2643-2644-2645-2646-2647-2648-2649-2650-

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1515 (M)
45M - 1-1-69

| | | | | | | | | | | | |
|--|--|--|--------------------------|--|--|---|--|-----------------|---------|--|------|
| 03689 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 03684 | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Lost | 2a. DATE OF DEATH | | 2b. HOUR | | | |
| VICKY | | | LYNN | WRIGHT | | March Month 20 Day 1969 | | 5:38 A.M. | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| Female | | White | | October 8, 1956 | | 12 YRS. | | MONTHS | | DAYS | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Maryland | | USA | | | | Baltimore | | | | Md. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Towson | | ST. JOSEPH HOSPITAL | | Student | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13d. STREET AND NUMBER | | | | | |
| Maryland | | Baltimore | | | | 9629 Mason Ave. | | 21234 | | | |
| 14. FATHER'S NAME | | | First | Middle | Lost | 15. MOTHER'S MAIDEN NAME | | | First | Middle | Lost |
| James | | | A. | Wright | | Emma | | | RILEY | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | |
| No | | | None | | | Hospital records | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute bronchopneumonia.</u>
<u>485X</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <u>Reyes syndrome.</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (A) (this hospital) attended the deceased from <u>March 15</u> , 19 <u>69</u> , to <u>March 20</u> , 19 <u>69</u> , that (A) (we) lost saw the deceased alive on <u>March 15</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>[Signature]</u> | | | | | DEGREE
ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<u>March 20, 1969</u> | | | | |
| 22d. PHYSICIAN'S NAME (Type)
<u>Kaq Lawrence F. Misanik, M.D.</u> | | | | | 22e. ADDRESS
<u>7620 York Road, Towson, Md. 21204</u> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| Burial | | 3/24/69 | | Dulaney Valley Mem. | | Timonium Balto Md. | | | | | |
| 24. FUNERAL DIRECTOR
ADDRESS
<u>C.F.EVANS & SON 8802 Harford road</u> | | | | | 25a. REC'D BY REGISTRAR
<u>MAR 21 1969</u> | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|--|--|--|--|---|---|---|--|--|------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| 03690 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 03685 | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | | |
| HARRY AUGUST YOUNG | | | | | | MARCH Month 24 Day 1969 Year | | 8A. M | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | |
| M | | W | | JULY 7, 1896 | | 72 YRS. | | IF UNDER 24 HRS.
HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| MD. | | U. S. A. | | | | BALTIMORE Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| CATONSVILLE | | | 1117 MCADOO AVE. | | | SIGN PAINTER-RET. | | U. S. Gov. | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | |
| MD | | | BALTIMORE | | CATONSVILLE | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 1117 MCADOO AVE. 21207 | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | |
| GEORGE W. YOUNG | | | GENEVIEVE BAEK | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | |
| YES | | | U. W. I | | 215-03-1704 Esther M. Young-1117 MCADOO AVE. 21207 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Coronary Occlusion, Acute | | | | | | | | Sudden | | |
| 4109 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | 6 yrs. | | |
| (b) Arteriosclerotic Cardio-vascular Disease | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (c) | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| | | | | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from Aug. 1959, to March 1969, that (I) (we) last saw the deceased alive on March 15 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | | |
| Leo J. Gaver, M.D. | | | | | | | | March 24, 1969 | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS | | | | | | |
| | | | | 1 Mallow Hill Ave., Baltimore, Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | 3-27-69 | | Balt. National Cem. | | Baltimore Md. | | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
| Forley-Crawford, H. Catonsville, Md. | | | | MAR 28 1969 | | Charles Jones | | | | |

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COPIES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
|---|--|--|---|---|---|---|--|--|--|-------------------------------|
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) MARGARET | | | First NMN | | Middle ZASSENHAUS | | Last | | 2a. DATE OF DEATH
3 Month 14 Day 69 Year | 2b. HOUR
5:28 M |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
8/18/1891 | | 6. AGE (in years last birth)
77 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country)
Germany | | 7b. CITIZEN OF WHAT COUNTRY?
Germany | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore, Md. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore, Md. | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
GBMC | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN Rodgers Forge | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
7028 Bellona Ave. | |
| 14. FATHER'S NAME
First W. Middle Last Ziegler | | | 15. MOTHER'S MAIDEN NAME
First Middle Last Unknown | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
079-28-7434 | | 17. INFORMANT
Address 12 Dr. H. Margaret Zassenhaus 7028 Bellona Ave. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Mesenteric thrombosis with acute peritonitis | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF and infarction of small intestine | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | |
| (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ | | | | | | | | | | |
| (c) _____ | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Hypertensive cardiovascular disease | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/10/ 19 69 , to 3/14/ 19 69 , that (I) (we) last saw the deceased alive on 3/14/ 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<i>Rudiger Breitenecker</i> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | 22c. DATE SIGNED
3/14/69 | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Rudiger Breitenecker, M. D. | | | | | | 22e. ADDRESS
Greater Baltimore Medical Center | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | | 23b. DATE
3/14/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Greenmount Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | | | | |
| 24. FUNERAL DIRECTOR
Mitchell-Wiedefeld ADDRESS 6500 York Road 21212 | | | | | | 25a. REC'D BY REGISTRAR
DATE MAR 17 1969 | | 25b. REGISTRAR'S SIGNATURE
<i>Charles J. J...</i> | | |

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|-----------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| 03692 | | | | | 03687 | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | | | 2a. DATE OF DEATH | | | 2b. HOUR | | | |
| First | | | Middle | | Last | | | Month Day Year | | HRS. MIN. | |
| ANNIE | | | SARAH | | ZLOTOWITZ | | | MARCH 14, 1969 | | 7 PM | |
| 3. SEX | | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | |
| FEMALE | | | WHITE | | | | | 82 YRS. | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | |
| POLAND | | | U.S.A. | | | | | BLATIMORE Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| BALTIMORE | | | 6990 MARSUE DR., APT. 1 A | | | HOUSEWIFE | | | AT HOME | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| MARYLAND | | | BALTIMORE | | BALTIMORE | | | | 6990 MARSUE DR., APT. 1 A | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | |
| LUMER | | | UNKNOWN | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | Address | |
| NO | | | 217-34-9125 | | MR. SAM ZLOTOWITZ | | | | | 3625 FOREST GARDEN AVENUE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Acute Pulmonary Edema | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (b) Acute Myocardial Infarction | | | | | | | | | | Puddle | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) Rheumatic Fever | | | | | | | | | | 14 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb 15, 19 69, to March 14, 1969, that (I) (we) last saw the deceased alive on March 14, 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Cecil Rudner MD | | | | | | | | | | 22c. DATE SIGNED 3-15-69 | |
| 22d. PHYSICIAN'S NAME (Type) CECIL RUDNER | | | | | | | | | | 22e. ADDRESS 6821 REISTERSTOWN ROAD | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | |
| BURIAL | | | 3-16-69 | | PROGRESSIVE RUDEO RUSS VEREIN, ROSEDALE, MARYLAND | | | | | | |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
| | | | | | MAR 18 1969 | | | | | | |

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